IPAS/PASARR Program Manual
Transmittal #3

SECTION	PAGES NEW	PAGES OLD	DESCRIPTION
Manual Issuance: 1/30/96	Section 100, 200, Appendices	NA	Issuance of IPAS/PASARR Program Manual
New Section 210: Resident Review Issued 7/1/97	65-78n*	65-78	Changes process for PASARR Resident Review (RR) in compliance with P.L. 104-315, effective 7/1/97. This Section was issued and distributed as Medicaid Bulletin E97-21, dated August 15, 1997. Note: *Pages 76-78 were inadvertently deleted when font size was reduced for printing as a Medicaid Bulletin. The chart on page 68a is no longer applicable.
Revised Manual Issuance: 01/01/00	New Chapters 1 – 19, Glossary, and Appendices	NA	Entire Manual revised, reformatted, and reissued.

This page is intentionally blank.

IPAS/PASARR Program Manual

INTRODUCTION

Introduction, Purpose and Scope, Design, Use and Distribution of the IPAS/PASARR Program Manual

Introduction

Indiana's state-required PreAdmission Screening (IPAS) and the federal PreAdmission Screening and Annual Resident Review (PASARR) programs are administered by Indiana's Family and Social Services Administration (FSSA), Division of Disability, Aging and Rehabilitative Services (DDARS), Bureau of Aging and In-Home Services (BAIHS) working in coordination with the Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health (DMH).

At the local level, these programs are operated by the 16 Area Agencies on Aging (AAA) acting as the designated IPAS agencies, the 30 Community Mental Health Centers (CMHCs), and the eight (8) Bureau of Developmental Disabilities Services (BDDS) offices working with the five (5) Diagnostic and Evaluation (D&E) Teams. All Indiana licensed nursing facilities (NFs) and hospitals are also involved in this operation.

Purpose and Scope of the Manual

This manual provides instructions and procedures for determining eligibility for admission to and/or continued residence in state licensed and/or Medicaid certified nursing facility (NF) beds in Indiana. These instructions are in compliance with State and Federal laws and regulations governing the IPAS and PASARR programs. Also included are the procedures to be followed by IPAS Agencies, NFs, hospitals, CMHCs, BDDS Field Offices, D&E Teams and other involved entities to administer and comply with applicable laws and regulations. This Manual is maintained in both hard copy and electronic versions (Word Perfect). To obtain it on diskette, please provide two (2) blank diskettes to the Division.

Design

The manual is designed in an expanded outline format that contains four (4) Sections: Introduction; Program Section 100 - IPAS Procedures; Program Section 200 - PASARR Procedures; and Appendices. Each Section is subdivided by chapters, and each chapter is preceeded by a Table of Contents. The Appendix Section at the end contains a listing of program acronyms and definitions, other addendums, program forms (in order of usage), and an index.

All requirements in this manual are based on State and/or Federal laws and regulations. The manual itself is not promulgated.

Manual Updates

When required, numbered Manual Transmittal Bulletins/Letters will be used to transmit hard copies of new or revised manual material and updated pages. Each Letter will have a "transmittal number" which is to be recorded, along with the date of issuance, on the attached list of Manual Transmittal Letters. Obsolete material should then be removed and replaced by the new/revised material as directed in the Transmittal Letter. KEEP YOUR COPY OF THE MANUAL CURRENT OR IT IS USELESS. Contact your local IPAS Agency with questions concerning manual updates or to obtain missing material.

Use

The program manual is the primary tool for program operation and compliance. As with any tool, skilled use comes with both training and experience. Contact your local IPAS agency with questions or additional training requests.

Use the Tables of Contents to locate general topics and the Index to find specific items. Once material is located, read the entire

text regarding the topic.

Distribution

Initial distribution of the IPAS/PASARR Program Manual is made to the 16 IPAS Agencies (AAAs) which will distribute copies to local NFs, hospital Social Work Departments, CMHC OBRA/PASARR contact persons, BDDS Integrated Field Services offices, D&E Teams and other involved entities. When additional copies of the manual are needed, the local IPAS Agency is to notify the State PASARR Program at the BAIHS, DDARS, which maintains the distribution list.

IPAS & PASRR MANUAL

Master Table of Contents

IPAS & PASRR MANUAL

Table of Contents

THIS PAGE INTENTIONALLY LEFT BLANK.

Chapter 1

INTRODUCTION

1.1 PROGRAM BASIS

Indiana's PreAdmission Screening Program (IPAS) was created by Public Law 21, Acts of 1982. It was implemented statewide on April 30, 1983. Indiana Code (IC) 12-10-12 and 460 Indiana Administrative Code 460 (IAC) 1-1 codify the law and rules under which IPAS operates.

PAS is administered by the Bureau of Aging and In-Home Services (BAIHS) of the Division of Disability, Aging, and Rehabilitative Services (DDARS) of the Indiana Family and Social Services Administration (FSSA) through the 16 Area Agencies on Aging, designated as IPAS agencies.

NOTE: To avoid confusion with the preadmission screening (PAS) function of the "PASRR" program, Indiana's PreAdmission Screening program will be identified as "IPAS."

1.2 GOAL AND PURPOSE OF IPAS

The goal of IPAS is to prevent premature or unnecessary placement in a nursing facility (NF) of individuals whose long-term care needs do not require NF level of services or can be more appropriately met through in-home and community-based services. IPAS provides the opportunity for the provision of long-term care services in a location conducive to the physical and psychological well-being of an individual.

The objectives of IPAS are:

- to identify individuals who are "at-risk" of institutionalization and meet the state's criteria for NF placement;
- to provide a comprehensive assessment of an individual's needs;
- to ascertain whether alternative services are available in the community that would be more appropriate than care in a NF at not more than the cost of placement in a NF;
- to deny entrance to a NF when the criteria are not met, unless an individual is willing to forego eligibility for Medicaid reimbursement for NF per diem costs for a period of up to one year from the date of admission to a NF; and
- to meet the requirements of the PAS-portion of Indiana's PASRR program.

1.3 RELATIONSHIP OF IPAS TO PASRR

The federal PreAdmission Screening and Resident Review (PASRR) program is required to interface with existing or future nursing facility (NF) preadmission screening and resident assessment procedures to the greatest extent possible.

Through its Medicaid State Plan, Indiana incorporates and utilizes Indiana's IPAS program in the PASRR process. IPAS thus provides the following functions for the PAS portion of the PASRR program:

- identification of persons seeking admission to Medicaid certified NFs;
- review and certification of need for the Level II assessment on the Level I form;
- written notice to the individual of referral for Level II;
- activation mechanism to complete a Level II assessment to the CMHC or D&E Team;
- provision of necessary data to evaluate and determine need for NF level of care including physical status, functional assessment (activities of daily living), alternative services and/or placement;
- liaison between NF, family, physician, and other entities as necessary;
- review of documentation and recommendation for placement;
- coordinating entity to compile PAS case documents for submission to the State;
- entity to disseminate information and procedural directions including linkage with the State PASRR program; and
- distribution, retention, and preservation of case records.

For information and procedures for Indiana's PASRR program, see Chapters 10-16 of this

INTERRELATIONSHIP OF IPAS AND PASRR
Chapter 1

IPAS PAS of PASRR RR of PASRR

IPAS

1. All Indiana Licensed NFs
2. All Applicants and Residents, Regardless of Payment Source

PASRR

1. All Medicaid-Certified NFs
2. All Applicants and Residents, Regardless of Payment Source

PROCESSING OF PAS AND RR
Chapter 1

IPAS and PAS of PASRR

Applies to Admission: Initial Contact at NF, Hospital, Community, AAA, Other

Referral to AAA

Private Pay: No Level II

AAA Makes Final Determination (Note: Denials Sent to OMPP)

Medicaid Recipient, Applicant, or Will Apply: No Level II

OMPP Makes Final Determination

Needs PAS/PASRR Level II

Refer for Level II to:

- CMHC for MI
- D&E Team for MR/DD or MI/MR/DD

Send PAS RR to AAA

RR of PASRR

Applies to:
1. Resident of NF; or
2. Inpatient Hospital Acute-Care Bed Admitted from NF

Needs Level II

Prior Level II Completed: May Readmit to NF (new Level II done after Readmission)

Hospital Completes Level II (MI Only): Send To:

NF will Forward to:

State PASRR Unit: Makes Final Determination

No Level II Need

May Readmit Directly to NF

Final Determination

NF Placement Is Appropriate

NF Placement Is Denied For:

- No Need for NF Level of Services
- Needs Specialized Services Not Available in NF
- Cost-Effective Available Community/In-Home Services to Meet Needs

Denials May Request:

- Reconsideration; and/or
- Fair Hearing Through Medicaid Appeals Process

This page is intentionally blank.

IPAS & PASRR MANUAL

Table of Contents

Chapter 2

IPAS APPLICATION AND LEVEL I

Indiana Code (IC) 12-10-12 prohibits an Indiana NF licensed under IC 16-28 from admitting or retaining any individual without complying with IPAS program requirements. (See Chapters 1-9.) If the NF is Medicaid-certified, PASRR program requirements also apply. (See Chapters 10-18.)

2.1 PARTICIPATION REQUIREMENTS

IC 12-10-12 places the responsibility on the NF to assure that all admissions and NF stays are in compliance with applicable IPAS and PASRR laws and regulations. NFs should contact the local IPAS agency if there are questions.

2.1.1 Indiana Licensed NFs

Every nursing facility (NF) operating in Indiana which provides NF comprehensive-care level of services must be licensed. Medicaid and/or Medicare may also certify a NF to provide NF level of services.

a) "Free standing" NF beds are licensed under IC 16-28-2 (long-term care).
b) "Hospital-based" NF beds may be licensed either under IC 16-21-2 (hospital) or IC 16-28-2 (long-term care), according to the facility's or unit's administrative structure.

In Indiana, every NF licensed under IC l6-28-2 must participate in the IPAS program. (See Chapter 3.10 for IPAS requirements for hospital-based NF units.)

To verify licensure status, refer to the Indiana Health Facilities Directory, published annually by the Indiana State Department of Health (ISDOH). Free-standing NFs are listed in the main section of the Directory. Hospital-based hospital-licensed NFs (licensed under IC 16-21-2) are listed in a separate section at the back of the Directory.

IPAS PARTICIPATION REQUIREMENTS
Chapter 2.1

	IPAS	**PASRR**
	PAS	PAS-of-PASRR	RR-of-PASRR
1.	All Indiana Licensed NFs	All Medicaid-Certified NFs
2.	All Applicants and Residents, Regardless of Payment Source	All Applicants and Residents, Regardless of Payment Source
	PAS and PAS-of-PASRR Admission and Assessment Process: See Chapters 3, 4, and 13.	RR-of-PASRR Assessment Process: See Chapters 14.

2.1.2 Applicant

For IPAS and PASRR purposes, a PAS applicant is an individual seeking either temporary or long-term admission to an Indiana licensed NF.

ALL applicants are required to participate in IPAS, regardless of the source or method of NF payment which will be used. "Regardless of source or method of payment" includes such sources of payment as Medicare, Medicaid, VA contract, insurance, private-pay, and any other means of payment for a stay in any NF.

Refusal to participate, with admission to the NF or continued residence in a NF after an IPAS denial, will result in an IPAS penalty for the individual. (See Chapter 6.2 of this Manual.)

2.1.2.1 "Grandparent" Provision

Individuals are exempted from the IPAS requirements set out in IC 12-10-12 if they were:

a) admitted to a NF prior to implementation of the IPAS program on April 30, 1983; and
b) have not been discharged to a community-based or other institutional living arrangement.

When a resident who qualifies under the "grandparent" provision requests Medicaid reimbursement, the NF will clearly document to OMPP why the individual was exempted from IPAS, including the date of original NF admission.

NOTE: "Grandparented" residents are not exempted from compliance with RR provisions under PASRR.

2.1.2.2 State Psychiatric Hospital Resident

Regardless of the responses on PASRR Level I (including the "Dementia Exclusion"), ALL residents of State psychiatric hospitals must participate in a full PASRR Level II assessment and determination PRIOR to any NF admission.

2.1.2.3 Nonresident

See Chapter 3.8 for requirements and procedures.

2.2 "NEW ADMISSION"

IPAS participation is required for each "new admission" to a NF. For IPAS purposes, situations that require assessment may be, but are not limited to:

a) first-time admission to an Indiana NF; or
b) new admission following discharge to an alternative (non-NF) living arrangement; or
c) residence under the following circumstances:
   1. never notified of the IPAS requirement; or
   2. under IPAS penalty but qualifies as "SNF level of care" and applying for relief of the remainder of the penalty period. (See Chapter 6.2.)

The IPAS agency will always research the IPAS status of each applicant before processing the Application form. This includes a review of agency records, questioning the NF, applicant, family, and/or representative, and identifying past NF admission history for the applicant. (Also see Chapter 2.4.)

2.2.1 IPAS Required

IPAS assessment is required for:

a) initial admission to a NF;
b) admission after NF discharge to a community-living arrangement for a period of more than 24-hours;
c) NF residence without notification of IPAS requirements (completion of Application form, etc.), regardless of the length of NF residence; and
d) admission requiring PASRR Level II assessment. (See Chapter 10.3.4.)

NOTE: IPAS participation is required regardless of Medicare reimbursement status or Medicaid "15-day bed-hold" policy.

2.2.2 IPAS NOT Required

The IPAS agency will NOT process IPAS assessment for the following situations, regardless of the number of Application forms completed:

a) individuals currently being assessed for IPAS (see Chapter 2.4.1);
b) residents under IPAS penalty, unless the individual has a need for the level of NF services characterized as SNF under Indiana's Medicaid Rule (see Chapter 6.2);
c) readmissions to the same or a different NF, regardless of hospitalizations or therapeutic leaves which exceeded the Medicaid "15-day bed-hold limit" (see Chapter 2.4.5); and
d) transfers between NFs (see Chapter 2.9).

2.3 FORMS FOR IPAS/PASRR APPLICATION

Application for participation in IPAS is the first step in the IPAS (and PAS/PASRR) process.

2.3.1 NF "Notice to Applicant"

The IPAS Program Information sheet was developed to assist the NF in this task. (See Chapter 2.3.3.) The NF must:
a) notify every individual applying for admission, in writing, of the IPAS requirements; and
b) provide the IPAS Information Sheet; and
c) have the individual complete the Level I; and
d) assure that the IPAS Application form is completed.
Failure to follow admission requirements, including notification and completion of the IPAS Application constitutes a Class A infraction by the NF. (See Chapter 6.3.)

The IPAS Notice by the NF must include the following information:
1. every applicant for NF admission is required by state law to apply for participation in the IPAS program; and
2. the applicant's failure to participate in IPAS could result in the applicant's ineligibility for Medicaid reimbursement for per diem in any Indiana licensed NF for up to one (1) year (See Chapter 113); and
3. the IPAS program consists of an assessment of the applicant's need for nursing care in a NF made by a team of professionals familiar with the needs of individuals seeking admission to nursing facilities.

2.3.2 Forms for Application

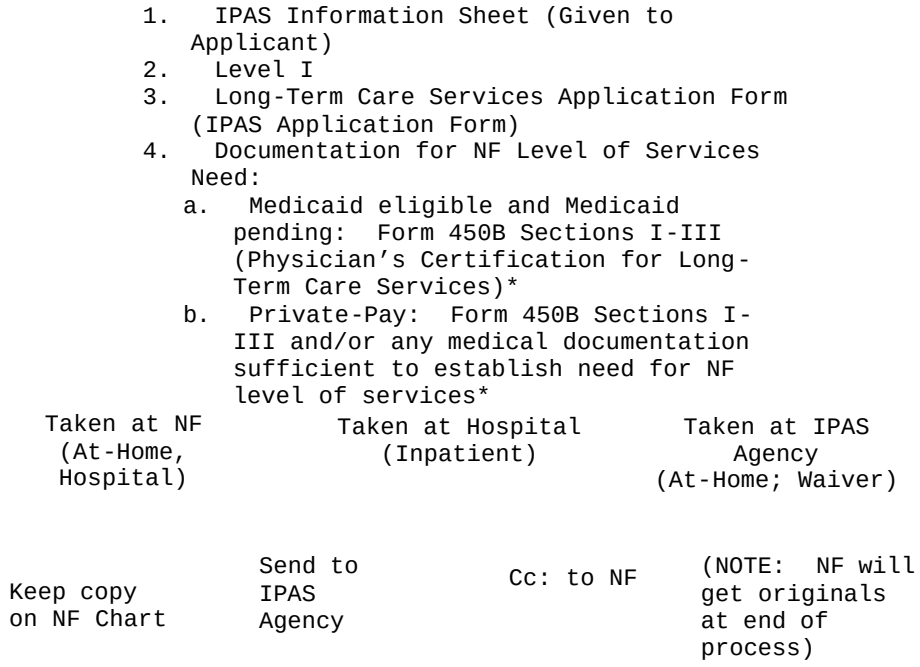
The "complete" IPAS Application consists of the:
a) IPAS Program Information Sheet (See Appendix K); and
b) "Application for Long-Term Care Services" form (See Appendix L), herein referred to as the "IPAS Application;" and
c) Level I: Identification Evaluation Criteria screen, completed in conjunction with the Application, to identify need for Level II (See Appendix U); and
d) for designee-authorized long-term admissions, Physician Certification for Long-Term Care on the Form 450B, Sections I-III (See Appendix M); and
e) for MR/DD applicants, Physician Certification for Long-Term Care Services(Physical Examination for PASRR Level II), Form 450B, Section VI.

The NF must assure that an applicant (or the applicant's parent, guardian, or legal representative) has completed and signed the Application for Long-Term Care Services (IPAS Application) form:

a) PRIOR to admission; or
b) within twenty-four hours following admission for non-PASRR, IPAS designee-authorized, admissions. (See Chapter 3.)

IPAS APPLICATION DOCUMENTATION
AND ROUTING OF DOCUMENTS
Chapter 2.3

Required Application Documents:



The NF will review the application forms PRIOR to forwarding them to the IPAS agency to assure appropriate completion. All necessary portions of the IPAS Application and Level I forms will be completed before the IPAS Eligibility Screen can be initiated.

NOTE: When a resident is transferred to another NF, the Application packet and pertinent IPAS and/or PASRR documents must be forwarded by the discharging NF to the admitting NF in a timely manner. (See Chapter 3.9.)

2.3.3 IPAS Program Information Sheet

The IPAS Information Sheet explains the requirement to participate in IPAS, the program's intent and process, and the penalty for non-participation. (See Appendix K.) It is given to the individual or his or her legal representative when an inquiry is made regarding NF admission. Use of the IPAS Information Sheet assures that the applicant has received the information which the law requires the NF to provide. (See Chapter 2.3.1.)

2.3.4 Application Completion

When the NF finds that it is probable that the individual will enter the facility, the NF will have an IPAS Application form completed. (To avoid unnecessary assessments, casual inquiries are not referred for application.)

2.3.4.1 At NF

It is the responsibility of the NF to:

a) assure that the individual has made an informed decision;
b) assure that the form is completely filled out; and
c) provide verification that application for IPAS was made in a timely manner.

An "IPAS Application" form (Long-Term Care Services Application) is completed until all applicable items have been entered, and it is signed and dated. An incomplete IPAS Application will be returned to the NF for completion. Applicable receipt and return dates will be clearly stamped and documented on the IPAS Application form by the IPAS agency. An explanation should also be included in the case narrative.

It is the responsibility of the NF or, if completed at the hospital, of the hospital discharge planner to assist the applicant and/or his/her legal representative to complete the application process.

2.3.4.2 At Hospital

The Application form may be partially completed at the hospital for "Direct From Hospital" designee authorized temporary admissions. (See Chapter 3.7.3.2.)

2.3.4.3 At Home

The Application form may be completed in the applicant's home with the assistance of the IPAS agency's care manager or IPAS assessor. When acting in this role, the care manager or assessor must follow the same procedures as required of the NF. If a NF has been selected by the applicant, the care manager or assessor must assure that it receives a copy of the completed Application form and Level I in a timely manner.

2.3.5 Signature

The following protocol will be followed for signature on the IPAS Application form:

a) applicant;
b) parent, guardian, or health care power of attorney when the applicant is a minor or has been adjudicated legally incompetent;
c) health care representative appointed by the applicant;
d) applicant's spouse;
e) applicant's adult child;
f) applicant's adult sibling;
g) applicant's religious superior, if the applicant is a member of a religious order;
h) the person allowed to sign papers for hospital care and services or for NF placement and services;
i) any other person acting on behalf of and in the best interest interest of the applicant, and in the absence of a conflict of interest; or
j) the NF administrator, as a last resort, if there is a statement regarding the reason other choices are not available and a conflict of interest does not exist.

An individual signing on behalf of the applicant must have sufficient knowledge of the applicant's situation and condition to be able to answer questions pertaining to the Application form and the PASRR Level I screen.

2.3.6 Transmittal and Retention

The NF will:

1. give a copy of the completed Application form to the applicant;
2. retain one (1) signed copy of the Application form on file for at least one (1) year; and
3. deliver the original signed copy of the IPAS Application form and Level I (and, if applicable, the Form 450B) to the IPAS agency serving the county in which the applicant resides.

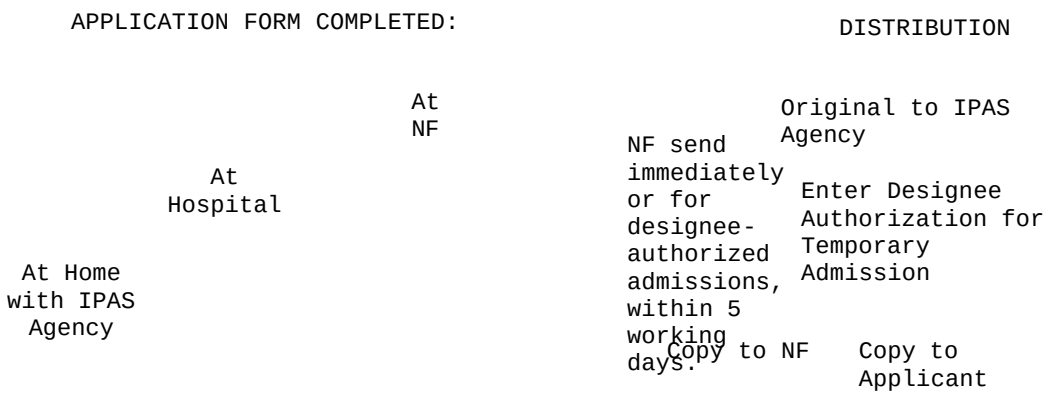
Although a hospital or IPAS agency may take the Application forms, the NF is responsible to assure that the above requirements are met.

For designee authorized admissions, the NF will assure that the IPAS application and other designated documentation are forwarded to the IPAS agency no later than:

a) immediately following the applicant's signature on the Application form; or
b) if the individual is admitted to the NF under designee authorization, within five (5) working days from the date of NF admission.

When the IPAS application is completed at the hospital or with the assistance of the IPAS agency assessor, the NF must receive it as soon as possible, but no later than at admission.

DISPOSITION OF APPLICATION FORM
Chapter 2.3.3



2.3.7 Late Applications

IPAS Applications submitted by the NF after the appropriate time limits have expired, or after an inappropriate admission, will still be processed as an IPAS assessment request. However, the NF may be reported as having committed a Class A Infraction for failure to deliver the application in a timely manner. (See Chapter 6.3.)

NOTE: Medicaid reimbursement for NF per diem can only be provided to individuals who meet Medicaid requirements as well as IPAS program requirements.

2.4 DUPLICATE/UNNECESSARY APPLICATIONS

Only one (1) Application form is valid until a PAS Form 4B is issued to close the case.

The IPAS agency must:
a. review each Application form received to determine whether it is valid and should be processed; and
b. ask sufficient questions of the referring NF, the applicant, and the family to determine:
   1) the status of the individual's immediate past placement and care history; and
   2) the completion of other Application form at another NF.

The IPAS agency should quickly review its records to ascertain whether it has an IPAS assessment currently in process. Action to process the assessment will be stopped as soon as it is found that the IPAS application was inappropriately completed.

The IPAS agency will clearly:
a) mark any additional/duplicate Application form(s), "void;"
b) make a notation of why the Application form has been voided;
c) list the date of the current Application form on the duplicate copy, initial and date;
d) retain a copy of the voided Application form in the IPAS agency’s file; and
e) return the original of the voided Application form to the NF.

2.4.1 Application in Another Area

Questioning should reveal whether an Application form has been completed at a NF in another IPAS agency’s area. (See Chapter 2.4.4.)

2.4.2 Transfer Between NFs

NFs are required to transfer the IPAS Application form and other pertinent IPAS documentation to any NF that admits the individual. (See Chapter 3.9.) Duplicate

Application forms should not be taken because of a transfer between NFs. If a duplicate is filled out, the IPAS agency will follow procedures in Chapter 2.4.

2.4.3 Transfer Between IPAS Agencies

Coordination between IPAS agencies is required when:

a) application for IPAS is made at a NF(s) in the catchment area(s) of more than one IPAS agency; or
b) an at-home applicant lives in the area of one IPAS agency, but requires emergency admission in the area of a different IPAS agency.

2.4.3.1 Process to Transfer Case

The IPAS agency serving the area in which the applicant resides will:

a) receive and review the Application form, Level I, and applicable application forms for completeness;
b) certify the Level I for Level II need;
c) act as IPAS designee for temporary NF admission when requested; and
d) transfer the case record, after the applicant is admitted, to the IPAS agency serving the area of the NF.

2.4.3.2 Process to Receive Case

The IPAS agency serving the area of the NF will:

a) act as liaison between the first IPAS agency and the NF, as needed;
b) receive and finalize the case processing;
c) issue the PAS Form 4B to notify applicable entities of the case disposition; and
d) maintain the case record on file.

2.4.4 New Versus Readmission

During questioning it may be revealed that the individual has been in more than one NF. The IPAS agency will need to establish the individual's placement history.

Review Chapter 2.2 for a discussion of "new admission." For purposes of IPAS and PASRR, "readmission" applies to direct transfer from one NF to another NF, with or without an intervening hospital stay. The individual remains within the cycle of long-term care without a return to a community living arrangement.

NOTE: The Medicaid "bed-hold" provision does not affect IPAS or PASRR. The "bed hold" provision only applies to Medicaid reimbursement. Do NOT take a new Application form or complete a new IPAS assessment unless the long-term care cycle has been interrupted. (For reimbursement only, the Medicaid bed-hold policy considers an individual as "discharged" from a NF if the individual's hospital stay exceeds 15 days. Contact OMPP for questions concerning Medicaid "bed hold" policy. See Chapter 2.7 for additional information on Medicaid reimbursement.)

2.4.5 IPAS Penalty

An Application form completed by an individual under IPAS penalty is not valid:

a) unless one (1) continuous year from the date of NF admission has passed; or
b) the IPAS penalty has been relieved due to "SNF" level of services need. (See Chapter 6.2.)

NOTE: An NF that admits an individual from another NF, either directly or via an intervening hospitalization, is responsible for obtaining a copy of the PAS Form 4B (or HCBS Form 3 or 7, for Waiver recipients) authorizing the initial admission. Without this documentation, a NF may be accepting an individual who is still subject to the IPAS penalty, was denied admission under the IPAS (and PASRR) regulations, or was never notified of the IPAS requirements.

2.4.6 HCB Waivers

Medicaid Waiver recipients of:

a) Aged and Disabled (A&D) Waiver; or
b) Medically Fragile Children's (MFC) Waiver

services must be assessed under IPAS to qualify for the Waiver's services. (See Chapter

7.)

Completion of PASRR Level II, however, is postponed until after the individual exercises his or her option to choose NF admission, but PRIOR to NF admission unless the recipient qualifies for PASRR APS or Exempted Hospital Discharge NF admission.

2.4.7 "Missed PAS" Level II

Missed PAS/PASRR Level II occurs when Level II should have been done as part of IPAS, but was never completed. The PASRR Level II assessment and determination must be completed as soon as the need for Level II is identified, within applicable PASRR time frames for "Missed Level II." (See Chapter 14.3.)

When the PAS Form 4B (or HCBS Form 3 or Form 7 for Waiver recipients) has already been issued because IPAS is done, the Level II is to be completed under RR of PASRR as a "Missed PAS Level II." (See Chapter 14.3.)

2.5 PASRR: IPAS AND LEVEL I

Every admission to a Medicaid certified NF must have a Level I: Identification Evaluation Criteria screen completed to determine the need for a Level II assessment.

2.5.1 Level I Form

The Level I is a screening tool which:

a) is part of the IPAS application form and accompanies the IPAS application when it is submitted to the IPAS agency;
b) consists of eight (8) questions;
c) is designed to ascertain whether the individual has or is suspected of having a condition of mental illness (MI) and/or mental retardation/developmental disability (MR/DD); and
d) is the initial determiner of need for Level II assessment.

(See Chapter 10 as well as instructions for completion of the Level I at Appendix F, Level I Decision-Making Protocol.)

2.5.1.1 Level I Completion

The entity completing the Level I must be:

a) a professional person;

b) having or be able to obtain sufficient knowledge of the applicant's condition to answer the eight (8) questions;

c) able to clarify unclear information; and

d) if applicable, able to document the reason prescribed psychotropic medications would not require Level II.

2.5.1.2 Level I Review

The IPAS agency will:
a) review the Level I and all additional collateral for completeness;
b) determine whether PASRR Level II assessment is required; and
c) certify the need for PASRR Level II assessment at the bottom of the Level I form. (Apply the Level I Decision-Making Protocol in Appendix F.)

NOTE: The Level I is not always the sole criterion for determining the need for Level II. Additional information which enhances or contradicts the responses on the Level I must be considered in the determining whether Level II is needed. When the decision to refer for Level II is contrary to responses on the Level I, the IPAS agency will make a clear notation on the Level I, documenting the reason for referral, sign or initial, and date the notation.

When it is determined that Level II assessment is needed, the applicant cannot refuse to participate in IPAS and be admitted to or remain in a Medicaid-certified NF. (See Chapter 10 for instructions on Level I.)

2.5.2 "Depression Screen"

Determination of need for Level II may be difficult when the diagnosis is "depression." The "Depression Screen" is a tool designed to assist IPAS agencies in making this decision. When "situational depression" is claimed, the Depression Screen will assess and document the duration and degree of intensity of the depression. (See Appendix V.)

NOTE: A diagnosis of Bi-polar Disorder, Major Depression, or any serious depression will always require Level II, regardless of claims that it is due to a "situation," either medical or otherwise.

If the PASRR/MI Level II will be delayed or deferred based on results of the Depression Screen, the IPAS agency will:

a) so note at the bottom of the Level I; and
b) enter the caveat from the back of the Depression Screen on the PAS Form 4A; and
c) include a copy of the Depression Screen in the case record; and
a) submit the case to the State PASRR Unit for determination.

2.6 PROCESSING APPLICATION FORM AND LEVEL I

The IPAS agency will date-stamp every document upon receipt.

2.6.1 Action by IPAS Agency

The IPAS agency will initiate the following steps as soon as it receives the Application form:

a) immediately review the application for completeness:
   1) assure that a box is checked for either "AGREE" or "DO NOT AGREE;
      (Applications checked "DO NOT AGREE" will not be assessed or, if the complete assessment is done in error, will not be fully billed by the IPAS agency.)
   2) review that the Application form is appropriately signed and dated; (
      (If signed by someone other than the applicant, check that the relationship is specified.)
b) assure that the appropriate written IPAS designee authorization for temporary admission is executed:
   1) as appropriate, an IPAS designee authorization will be entered:
      a. on the Application form; or
      b. for the "Exempted Hospital Discharge" exclusion, on the PASARR Level I by the physician; or
      c. on an attached, completed PASARR Categorical Determination form for PASRR respite or APS; and
   2) a copy of the properly executed designee authorization will be provided to the NF for its chart and the original retained in the IPAS case record to be submitted to the State;
c) review the PASARR Level I form to determine need for Level II assessment;

[The IPAS agency will certify either "Yes" or "No" on the bottom of the Level I to

specify whether Level II is needed. (See Appendix F.)]

NOTE: If Level II is needed, the individual cannot "REFUSE" to participate in IPAS and be admitted to or remain in a Medicaid-certified NF.

d) calculate applicable time frames for completion of each part of the IPAS process, including the following factors among others:
1) the nature of the assessment (IPAS-only or PAS/PASARR);
2) type of IPAS case (Medicaid or non-Medicaid, at-home, in a hospital, temporary admission to a NF);
3) nonresident.]
e) schedule and arrange for the IPAS assessment;

(This includes contacting as appropriate the applicant, his or her family or legal representative, and other persons who are knowledgeable about the applicant's condition and situation, assigning the case to an IPAS assessor, and beginning tracking of case processing.)

f) contact the designated attending physician to obtain the necessary medical documentation and related service needs information.

Upon request, the IPAS agency will provide the physician with a thorough explanation of:
a) IPAS including the appointment (under IC 12-10-12-14) of the attending physician as a team member;
b) IPAS goals and objectives;
c) the need for medical and mental health information; and
d) the need for expeditious completion of the necessary forms.

To expedite submission of necessary medical documentation, the IPAS agency may:
a) solicit assistance from a family member or the legal representative to contact the physician in this regard; and
b) encourage the hospital discharge planner to assist in getting the physician's signature on the Form 450B, Physician Certification for Long-Term Care Services.
Delay in receipt of medical documentation, including IPAS follow-up dates and results, will be documented by the IPAS agency in the IPAS case record.

NOTE: Delay in receipt of necessary medical documentation is the most common cause of case processing delay.

2.6.2 Referral for Level II

If referral for PASRR Level II assessment is needed, the IPAS agency will:
a) notify the applicant in writing that the Level II referral is being made as soon as the need for Level II assessment is identified; and
b) make referral for PASRR Level II for individuals with:
1) MI (mental illness) are made to the local CMHC (Community Mental Health Center) serving the NF identified by the applicant or his or her representative; or
2) MR/DD (mental retardation/developmental disability) or MR/DD/MI are made to the local D&E Team.

The IPAS agency may use the form letter in the Appendices to send notice of referral for Level II to the applicant. It may be copied on the IPAS agency's letterhead. (See Appendix X.) Follow PASRR procedures in Chapters 10-16.

NOTE: If Level II is NOT needed, a notice does not need to be sent.

2.6.3 "Refuse/Do Not Agree"

Medicaid regulations do not allow an individual who needs a PASRR Level II assessment to refuse IPAS and be admitted to or remain in a Medicaid certified NF.

When the individual is non-PASRR, he or she may "refuse to participate in IPAS" and the NF may admit the individual under IPAS penalty. The NF will:

a) provide a copy of the IPAS Information Sheet and allow sufficient time for the person signing the Application form to read it; and
b) assure that the applicant understands the possible consequences of refusing to agree to participate in IPAS; and
c) make a clear notation on the application form itself, including the stated reason for refusal (and other applicable information); and
d) sign and date the notation on the IPAS Application PRIOR to sending it to the IPAS agency; and
e) keep a copy of the IPAS Application on file for at least one (1) year if the individual who refuses to participate is admitted to the NF; and
f) send the original IPAS Application to the IPAS agency immediately [or no later than within five (5) working days for designee authorized temporary admissions].

The IPAS agency will issue a PAS Form 4B which states the penalty for nonparticipation in IPAS, including the dates under IPAS penalty. (For more detail, see the IPAS Penalty in Chapter 6.2.)

NOTE: A Medicaid recipient may refuse to participate in IPAS, be admitted, and incur the IPAS penalty. Medicaid reimbursement will not be available for NF per diem, however.

2.6.4 Case Termination PRIOR to IPAS Completion.

An IPAS agency will:

a) not pend an IPAS or PASRR case beyond applicable IPAS and/or PASRR processing time frames; or
b) if it is necessary to pend the case, clearly document the reason.

For example, do not pend a case because the individual has changed their decision or cannot make a decision on whether NF placement is still wanted. Terminate the case due to voluntary withdrawal, refusal to participate, or failure to cooperate, as applicable. (Also see Chapter 5.2)

2.7 MEDICAID REIMBURSEMENT WHEN IPAS NOT REQUIRED

When an individual becomes Medicaid eligible and needs Medicaid reimbursement after a PAS 4B has been issued, the NF will:

a) obtain documentation to support the patient's current need for NF level of services (level-of-care) on Form 450B; and
b) make a copy of the PAS 4B (or, for Medicaid Waiver recipients, HCBS Form 3 or 7 in lieu of the PAS Form 4B); and
c) state the reason for submission of the documentation at the top of the Form 450B; and
d) submit the documentation and request directly to OMPP.

If a period of IPAS penalty has expired, the NF should include:

a) the original date of NF admission; and
b) a certification that the one (1) year penalty period has expired.

NF REQUEST FOR MEDICAID REIMBURSEMENT
(IPAS Not Required)
Chapter 2.7

NF Note Reason for Request on
Form 450B (Physician

Certification Sec. I-III)

Possible Reasons Include:
1. Readmission from hospital;
2. Change in medical status affecting level of care;
3. Readmission after 15-Day Bed-hold expired;
4. Transfer from another NF;
5. Expiration of IPAS Penalty period;
6. Other

Send to OMPP:
1. New Form 450B, Sec. I-III (Physician's Certification); and
2. Form PAS 4B; or
3. For Waiver Recipients, HCBS Form 3 or Form 7 (See Appendices R and S)

To obtain a PAS 4B when one is not available on the resident's chart or file, the NF must:
a) contact the local IPAS agency (AAA);
b) contact the prior NF if the patient was admitted from another NF, with or without an intervening hospital stay; or
c) as a last resort, provide a written cover letter to OMPP with the Form 450B explaining why a PAS 4B is not being included.

The cover letter should include the following documents and/or information:
a) if available, a copy of the IPAS Application form; and
b) the date that the individual was first admitted to a NF in Indiana; and
c) assurances to OMPP that the individual has received continuous NF care since the original date of NF admission (no discharge to home or the community during that time); and
d) a statement from the applicable IPAS agency that it has been unable to locate a copy of the PAS Form 4B.

2.8 IPAS AND MEDICAID MCO

Medicaid recipients seeking admission to a NF may be enrolled in a Medicaid Managed Care Organization (MCO). NF admission for Medicaid MCO enrollees must meet all IPAS and PASRR requirements. Medicaid reimbursement for the NF stay is affected by the MCO status, however.

2.8.1 General Information

For IPAS and PASRR purposes, Medicaid MCO enrollee NF admissions are divided into two (2) categories:
a) "short-term NF placement;" and
b) "long-term NF placement."

Intended length of stay is the criterion to be used for these placements. Time frames for short-term placement are established according to current corresponding IPAS and PASRR criteria (See Chapter 3), except for Direct from Hospital placements (See Chapter 2.8.3.3.).

2.8.2 Identification of MCO Enrollees

It is important for the IPAS agency to identify the MCO enrollee status of NF applicants as soon as possible. Information on MCO status should be recorded:
a) on the Application for Long-Term Care Services for in the section for recording "Medicaid Status;"
b) in information provided by the NF;
c) through hospital discharge planner completion of Section II, Temporary Authorization, on the Application form;
d) by a statement of the applicant or health care representative; and/or

e) through other sources.

2.8.3 IPAS Agency Action

The IPAS agency has the following responsibilities:

a) inquire about MCO enrollee status for every applicant who is a Medicaid recipient
b) when it is indicated that the applicant is an MCO enrollee, confirm status by calling the MCO Helpline at 800/889-9949;
c) review the Application form for appropriate completion;
d) review the Level I and decide need for PASRR Level II;
e) assure that the Application form, PAS Form 4A, PAS Form 4B (when issued by IPAS agency for temporary admissions or case termination), and any other documents deemed applicable by the IPAS agency show MCO status in the Medicaid status sections;
f) issue IPAS agency designee IPAS and PASRR authorizations for temporary admission, including notation of MCO enrollee status; and
g) immediately forward a copy of completed PAS Form 4B to the applicable Medicaid MCO provider, including PAS Forms 4B giving authorization for temporary admission as well as final determinations.

Notations of MCO enrollee status must be readily identifiable by the NF, OMPP, State PASRR Unit, BDDS Offices, and other IPAS agencies.

2.8.4 Processing MCO Enrollee Cases

NF identification of MCO Enrollee status is a reimbursement issue. It is the responsibility of either the NF or the hospital to notify the MCO of NF placement as soon as possible. The role of the IPAS agency is to assist with early notification to the MCO whenever an IPAS applicant is found to be an MCO enrollee.

2.8.3.1 “Short-Term NF Placement”

Following current IPAS procedures, short-term NF placement:

a) may be designee authorized using the applicable IPAS Direct from Hospital, Emergency/APS, 30-Day Short-Term, or PASRR Exempted Hospital Discharge, Respite or APS authorizations;
b) will use the current time frame restrictions for such admissions.

If circumstances change during the short-term NF placement in that the individual now needs long-term placement, current procedures are to be followed. The Medicaid MCO must be notified of any change.

The Medicaid MCO assumes financial responsibility for “short-term” NF placements. NFs must bill the applicable MCO directly and not submit a claim to Medicaid fee-for-service.

2.8.3.2 “Long-Term NF Placement”

When a Medicaid MCO enrollee is admitted to a NF for “long-term” NF placement, the Medicaid MCO must disenroll the recipient. Until disenrollment occurs, the Medicaid MCO is financially responsible for NF per diem reimbursement. After disenrollment is accomplished, the NF will submit its claims to Medicaid fee-for-service.

2.8.3.3 Direct from Hospital Admissions

Working with the Medicaid MCO, it is the responsibility of the hospital discharge planner to determine whether placement of an MCO enrolee is intended to be for a “short” or “long term.” The hospital discharge planner will follow current IPAS/PASRR procedures, including the following:

a) complete Section II on the Application for Long-Term Care Services form as applicable:
   1) check the box for “Direct from Hospital” for non-PASRR applicants;
   2) for PASRR Level II applicants, determine whether “Exempted Hospital Discharge” applies or whether the full IPAS/PASRR assessment needs to be completed prior to NF admission;
   3) check the box for “Medicaid MCO Enrollee;”
   4) check the appropriate box for short-term or long-term;
   5) check other boxes as applicable;
   6) enter the dates of authorized placement, using the date of NF admission as a start date; and

7) send the Application form and Level I to the IPAS agency with a copy to the admitting NF; and

b) follow other procedures as stipulated by Medicaid for the Medicaid MCO process.

NOTE: For Medicaid MCO IPAS “Direct from Hospital” authorized stays, “short-term” is defined to be a stay of less than 120 days in the NF. This differs from the usual limit of twenty-five (25) days for a Medicaid recipient, applicant, or will apply.

For IPAS “Direct from Hospital” Medicaid MCO enrollees, the IPAS agency will:

a) follow IPAS procedures for private-pay applicants; and

b) follow-up after ninety-five (95) days to determine whether the individual is still in the NF and whether discharge is planned prior to the expiration of 120 days.

If the individual has been admitted for a short-term stay, the IPAS agency will:

a) issue a PAS Form 4B to close the case at the expiration of the authorized time; and

b) send a copy of the PAS 4B to the Medicaid MCO.

If the individual needs to remain longer than the 120 days, it is the responsibility of the NF to:

a) notify the IPAS agency in writing of the reason the stay will last beyond 120 days; and

b) specify the length of time that will now be needed.

The IPAS agency will schedule completion of the IPAS assessment and determination within twenty-five (25) days, assuring that the Medicaid MCO receives a copy of the PAS Form 4B.

2.9 NF TRANSFER AND READMISSION

After IPAS has been completed and a form PAS 4B issued, the resident may transfer between NFs, with or without an intervening hospitals stay, without another IPAS assessment. Do NOT take a new IPAS Application form for an individual who is transferring in from one Indiana NF to another Indiana NF.

The transferring NF (NF #1) must:

a) transfer all IPAS and/or PASRR documentation with an individual to the new (admitting) NF; and

b) provide the original IPAS Application and Level I forms with, or prior to, transfer of the individual.

Medicaid and the ISDOH have always required transfer of pertinent medical documents and patient information between NFs. The transferring NF should retain a copy of the IPAS application and any other documents it deems necessary for at least one (1) year from the date of admission.

When patient transfer occurs before the IPAS process has been completed (PAS Form 4B has not been issued):

a) the new NF (NF #2) must immediately contact its IPAS agency to alert the IPAS agency to the transfer;

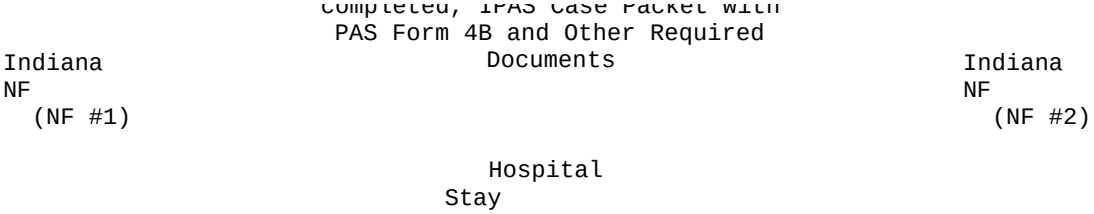
b) give to the IPAS agency the name, address, and phone number of the NF from which the patient is transferring; and

c) if NF #2 is in the area of a different IPAS agency, the IPAS agencies will work out an agreement for finishing the case processing; and

d) notify NF #2 of the results.

NF TRANSFER AND READMISSION
Chapter 2.9

Transfer Documents NF #1 sends to NF #2: IPAS Application and Level I Forms and, if IPAS is completed, IPAS Case Packet with



NOTE: When PASRR Level II is involved, refer to Chapter 14.

2.10 HOSPITAL-BASED NF UNITS

IPAS admission requirements for a hospital-based NF unit depend on the licensure, not survey, status of the hospital-based unit. See Chapter 3.8 for information on admission and discharge from hospital-based NF units.

This page is intentionally blank.

IPAS & PASRR MANUAL

Table of Contents

Chapter 3

ADMISSION REQUIREMENTS

All licensed Indiana NFs (under IC 16-28-2) must follow the admission requirements of IPAS (and, when Medicaid-certified, PASRR).

This Chapter will define the circumstances and parameters for admission into Indiana’s licensed nursing facilities (NFs).

NF REQUIREMENT FOR IPAS/PASRR
Chapter 3

Application for Admission to a NF

Indiana NF Licensed	Medicaid Certified NF
IPAS	PAS of PASRR

3.1 NF ADMISSION

See Chapter 2 for information on required forms for NF admission. This Section will provide information on IPAS admissions. For PASRR, refer to Section 200.

3.1.1 General Criteria

NF admission may be intended for:
a) short-term stay; or
b) long-term placement.
For IPAS purposes, “long-term” is generally defined to be a stay of 120 days or longer.

NF admission may occur:
a) after an IPAS and/or PASRR assessment and determination has been completed; or
b) with authorization for a temporary stay during which the IPAS and/or PASRR assessment and determination are in process; or

c) with authorization for a temporary period of time with discharge following the stay. Assessment and determination are not done.

IPAS (and, when required, PASRR) assessment and determination must be:
a) completed **PRIOR** to NF admission; or
b) within an authorized temporary time period and either:
1) completed following NF admission (Direct from Hospital, Emergency/APS, or PASRR APS); or
2) deferred until a later date (30-Day Short-Term, Respite, Five-Day Transfer Within CCRC, or PASRR Respite); or
c) not completed (Respite Stay, .30-Day Short-Term, PASRR Exempted Hospital Discharge, death, discharge home from the NF, etc.).

3.1.2 Time Frames

Most activities pertaining to IPAS and/or PASRR are governed by specific time frames. Use this chapter to refer to the type of NF admission contemplated to ascertain applicable time frames for case processing and temporary stays.

a) Establish need for Level II PRIOR to authorizing temporary admission:

Temporary admission authorizations and case processing time frames differ between IPAS and PASRR. Need for PASRR Level II assessment must be established before temporary authorization is given.

b) Time frame adjustment when case switches from private-pay to Medicaid:

When an individual who was admitted as private-pay indicates that Medicaid will be needed, the NF must immediately notify the IPAS agency. The IPAS agency will:

1) redesignate the case as a Medicaid case; and
2) adjust its time frame, as appropriate, to the Medicaid 25 day limit.

3.2 FROM HOME (OR OTHER NON-INSTITUTIONAL LIVING ARRANGEMENT)

Whenever possible, the IPAS assessment will be conducted in the applicant's home or other non-institutional living arrangement.
a) The most effective assessment of the individual’s current living environment and needs can be made in the home setting. When assessment is completed during temporary NF admission, the assessor should strive to identify functional limitations that would be present in a home or community living setting.
b) Alternative community services to support continuing independence and delay long-term NF placement also need to be based on availability within the locality of the home or community.

3.2.1 Time Frame

The IPAS assessment and final determination will be made:
a) as soon as possible, but no later than twenty-five (25) days from the date of signature on the Application form; and
b) when more time is required, the IPAS agency must clearly document the reason(s) and applicable dates the case is pended in the case record.

When "Emergency Admission" is required in the course of the At-Home assessment, an additional 25-days may be added to the expired time, not to exceed a total of 50 days. (See Chapters 3.2.4 and 3.4.)

3.2.2 Completion of IPAS Forms

The Application and Level l forms may be completed at the NF, or the IPAS agency representative may assist with completion of the IPAS Application form and Level I at the time of the home visit.

To expedite completion of the Form 450B, Physician Certification of Need for Long-Term Care Services, the IPAS assessor may give it to the applicant or a family member to deliver to the attending physician for completion. At times the physician is more responsive to a request from the family member. It is also helpful for the IPAS agency representative to give a preaddressed envelope to the applicant for the physician to mail the completed Form 450B directly to the IPAS agency.

3.2.3 NF Waiting Lists

When an individual intends to enter a NF, but his or her name is placed on a waiting list, the IPAS Application and assessment process will be completed within applicable time limits while the individual is awaiting placement. This allows the full assessment and final determination to be rendered during the waiting period. When the NF bed becomes available, expeditious placement can be made.

NOTE: The PAS Form 4B is only valid for 90 days from the date of issuance if the individual has not been admitted to a NF. NF admission terminates use of the 90-day period. (See Chapter 5.1.)

3.2.4 Emergency Admission During "From Home" Assessment

If an individual's condition and/or situation deteriorates to the point that an emergency occurs during the course of the "From Home" assessment, the IPAS agency may authorize "Emergency Admission" if the Emergency criteria are met. (See "Emergency Admission," Chapter 3.4.) The details of the emergency must be clearly explained in the case record.

3.3 TEMPORARY NF ADMISSIONS

An individual may be temporarily admitted to a NF either:

a) while the full IPAS assessment is in process, e.g., for an emergency; or
b) for a short stay when he or she meets criteria to be exempted from completion of full IPAS, e.g., for respite care.

Temporary stays must always have the IPAS designee's authorization PRIOR to NF admission (except for certain “Emergency/APS” admissions (see Chapter 3.4), and the "Five-Day Short-Term Within a CCRC" exemption (see Chapter 3.6). “Direct from Hospital” admission requires prior authorization from either the IPAS agency designee or the appointed hospital discharge planner designee (see Chapter 3.7),

3.3.1 Time Frame

Medicaid recipients, applicants, Medicaid pending and will-apply for Medicaid applications will always be completed as soon as possible, but no later than twenty-five (25) days from the date of application or that Medicaid status is identified.

When an individual who was admitted as private-pay indicates that Medicaid will be needed, the NF must immediately notify the IPAS agency. The IPAS agency will:

a) redesignate the case as a Medicaid case; and
b) adjust its time frame, as appropriate, to the Medicaid 25 day limit.

3.3.2 IPAS Designee

An IPAS designee is an individual appointed by the IPAS agency, with approval of BAIHS, who may authorize temporary admission to a NF. IPAS designees are individuals:

a) employed by the IPAS agency; or
b) employed as an Indiana hospital discharge planner and appointed by the IPAS agency.

NOTE: Hospital discharge planners are only allowed to authorize "Direct From Hospital" NF admissions for transfers from acute-care level beds only. (See Chapter 3.7.)

An individual acting as IPAS designee must:

a) assure that the Level I form has been completed;

b) assure that the IPAS Application form has been completed (See Chapter 3.7.3.2 for hospital instructions.);
c) make a preliminary judgment of the need for PASRR Level II assessment;
d) (IPAS agency only) complete certification of need for Level II at bottom of Level I;
e) determine whether requirements for temporary NF admission are met;
f) for long-term placement requests, gather sufficient information to make a decision of need for NF level of services, i.e., whether the applicant qualifies for at least temporary admittance to a NF because services necessary to care for the individual in the community are not available except in a NF setting (substantially complete assessment - see Chapter 3.3.3);
g) record the IPAS designee's authorization on the appropriate form (IPAS Application form or PASRR Categorical Determination form); and
h) for hospitalized applicants, check that a copy of the designee-authorized record from the hospital is transmitted to the NF in a timely manner, but no later than the date of admission.

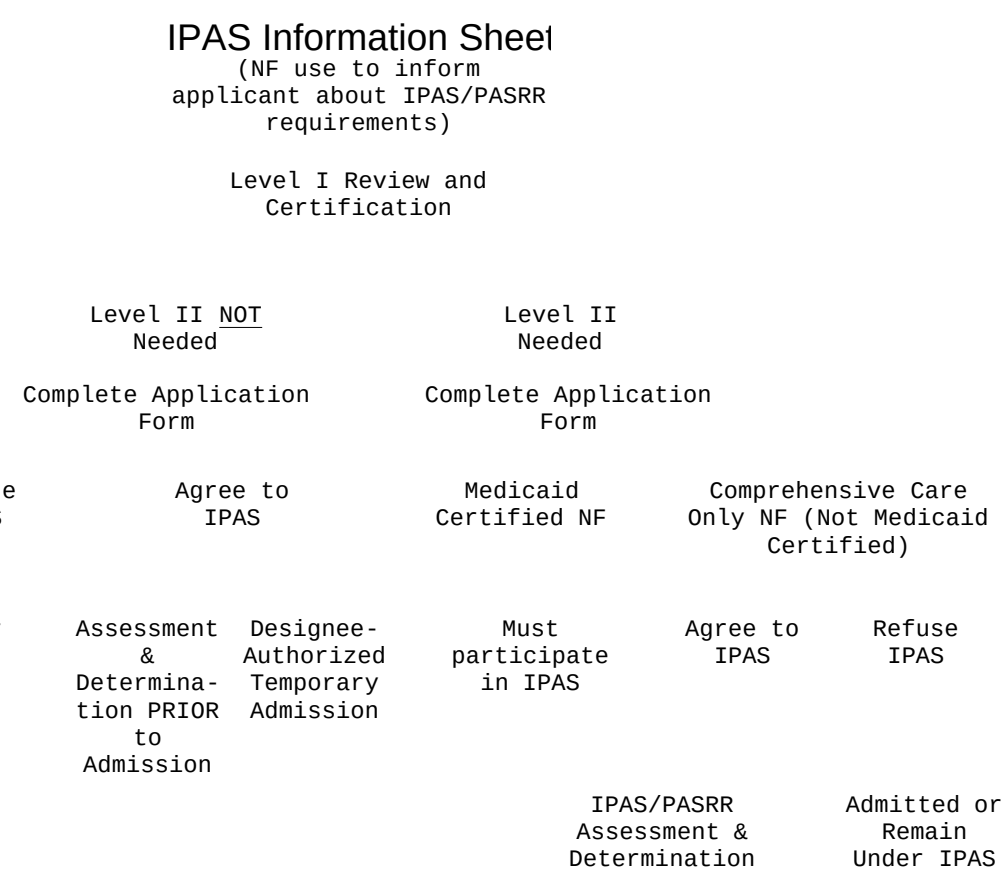
3.3.3 "Substantially Complete Assessment”

For long-term placements from an acute care hospital bed, an IPAS designee must conduct a "substantially complete IPAS assessment" (See Chapter 4.3.1.) to determine whether criteria for temporary NF services are met pending the completion of the entire IPAS assessment.

The entity requesting designee-authorization for temporary NF admission must provide sufficient information for the designee to determine whether the type of admission being requested meets requirements. A review of documentation and information will culminate in a judgment of whether requirements are met and temporary NF placement may be authorized.

The designee authorization for temporary NF placement is invalid if there is not sufficient information for a decision, or the information does not support the need for the temporary admission.

NF TEMPORARY ADMISSION PROCESS
Chapter 3.3



IPAS Direct from Hospital	IPAS Emergency/APS	IPAS Short-Term (30 Day)	IPAS 5-Day In CCRC			Penalty
				PRIOR to Admission	Designee-Authorized Temporary Admission	
NOTE: IPAS/PASRR assessment is completed prior to or following NF admission under IPAS or PASRR temporary Authorizations. For IPAS/PASRR Assessment and Determination process flow chart, see Chapter 4, Page 4.				PASRR Exempted Hospital Discharge	PASRR Respite	PASRR APS

3.3.4 Transmittal of Authorization

The IPAS designee must:

a) record in writing all decisions regarding the allowance or disallowance of temporary placement on the:
   1) IPAS Application form (for IPAS Only); or
   2) PASRR Level I form (for PASRR Exempted Hospital Discharge); or
   3) PASRR Categorical Determination form (for PASRR Respite or APS); and

b) provide notice of the decision to the applicant or his or her legal representative, the relevant NF, and the IPAS agency.

Designee authorizations by the IPAS agency may be transmitted by telephone in order to expedite NF placement. Written authorization must immediately be sent to the applicant and the NF for inclusion on the NF active record or chart.

The hospital discharge planner acting as designee must immediately transmit the necessary documentation to the NF. The NF is responsible to assure that it is forwarded to the IPAS agency, either by the NF itself or via the hospital. (Failure by the hospital to provide the NF with the necessary documentation of designee-authorization in a timely manner could result in the termination of designee status.)

The following chart shows the categories of temporary designee-authorized NF admission with applicable Chapters for quick reference. (PASRR details are addressed in Chapters 10-16.)

REFERENCE CHART FOR NF ADMISSION CATEGORIES
Chapter 3.3

Criteria for NF Admission

Nonresident: (IPAS Determination Completed PRIOR to NF Admission Unless Qualifies	From Home or Non-Institutional Community Living Arrangement: (IPAS Determination Completed PRIOR to NF Admission Unless Qualifies	IPAS Designee Authorized Temporary NF Admission: 1. Emergency/APS from Home 2. Short-Term (30-Day) from Home 3. Five-Day Within CCRC	PASRR Authorized NF Admissions: 1. Exclusions: a. Dementia b. Exempted Hospital Discharge 2. Categorical Determina-

Under Other Criteria in This Chapter) See Ch. 3.8 .	for Designee-Authorized Emergency/ APS) See Ch. 3.2 .	4. Direct from Hospital (See Chapter 3 for Informa- tion: 1. 3.4 2. 3.5 3. 3.6 4. 3.7)	tions: a. Respite Stay b. APS (See Ch. 13 for Details: 1a. 13.4 1b. 13.5 2a. 13.6.1 2b 13.6.2)

3.4 EMERGENCY/APS

Emergency admission, including Adult Protective Services (APS) situations, can only be granted:
a) for individuals residing at home or in a non-institutional living arrangement; or
b) from an emergency room of an Indiana hospital.
[Admissions from the emergency room or hospital 23-hour bed-hold (non-inpatient status) of an Indiana hospital licensed under IC 16-21 are covered in Chapter 3.7.6.]

Emergency/APS authorization does NOT apply:
a) to small group home settings as they are considered to be institutional living arrangements (Small group homes are licensed as intermediate care training facilities and are Medicaid reimbursed as institutions.);
b) if PASRR Level II assessment is needed (The only "emergency" admission provision under PASRR is qualification under “PASRR APS Categorical Determination.” See Chapter 207.322.):
c) to nonresidents (Only Indiana residents who are bona fide Indiana APS program participants qualify for the “APS” provision under Emergency/APS authorization.

3.4.1 Time Frame

The assessment and final determination must be completed as soon as possible but no later than twenty-five (25) days from the date of NF admission.

3.4.2 "Emergency" Defined

For purposes of IPAS, authorization for emergency admission:
a) "may be granted by the designee;
b) when a medical emergency exists in that care in the health facility is required within seventy-two (72) hours of the request for such admission; and
c) the attending physician certifies the need for such emergency admission" to the prescreening agency following IPAS procedures.

The physician’s certification of need for emergency NF admission must be:
a) based on the criteria listed above;
b) in writing; and
c) included in the applicant’s case record.

The IPAS agency must provide the IPAS definition of emergency to the physician.

3.4.3 Authorizing Entity

Only the IPAS agency designee may authorize Emergency/APS Admissions. The designee will:
a) determine and clearly record the nature of the emergency in the case record, obtaining as much information as possible relative to areas usually covered by the IPAS assessment (See Chapter 3.3.5.);
b) include a written certification by the attending physician; and
c) determine whether "Emergency/APS Admission" will be authorized.

3.4.4 Role of APS

When an individual is a bona fide APS recipient, the APS investigator may:
a) provide sufficient information so that the IPAS agency can determine whether emergency authorization will be granted; and
b) certify the emergency status and need for NF admission to the IPAS.

NOTE: The IPAS agency always has the responsibility to determine and document whether a bona fide emergency exists as defined in Chapter 3.4.2. The physician's and APS investigator’s

certifications constitute supporting documentation. They are not the sole criterion for determining approval of "Emergency/APS Admission."

3.4.5 Hospital ER or Hospital Bed-Hold

Only the IPAS agency designee may authorize admission from the emergency room (ER) or 23-hour bed-hold unit of an Indiana hospital. Authorization may or may not include APS-involvement.

The IPAS agency may appoint an APS investigator to:

a) act as an alternate designee when an after-hours IPAS agency on-call designee is not available;
b) gather information described in Chapter 3.4.6; and
c) certify on a format approved by the IPAS agency that the individual is the subject of a bona fide APS emergency.

APS authorization is only applicable until the IPAS agency is notified and approves the temporary NF admission. Both the NF and the APS designee are responsible for contacting and notifying the IPAS agency of the admission as soon as possible, but no later than the first working day following admission.

3.4.6 Supporting Information

When the NF contacts the IPAS agency (or APS) to request authorization for "Emergency/APS Admission" on behalf of an applicant, the NF will be prepared to provide as much of the following information as possible:

a) identifying demographic information for the applicant, including name, address, current location, etc.
b) the nature of the change in the individual's condition and/or situation which now causes them to seek emergency NF placement;
c) current APS involvement/intervention;
d) primary and secondary diagnoses (including physical/medical and mental diagnoses.);
e) prescribed medications including dosages, frequency, and reason(s) prescribed;
f) impairments in ADLs;
g) family and/or community services the individual is currently receiving;
h) name of a family member or legal representative who is knowledgeable about the situation and needs of the individual who can be contacted for additional information;
i) answers to the PASRR Level I screen;
j) history of recent hospitalizations or other inpatient care, including treatment and reason for treatment; and
k) any other information the PAS agency designee deems necessary in order to make a decision.

This information will be entered on a form developed by the IPAS agency as a "Documentation of Need for Emergency Admission" to be included in the IPAS case record.

3.5 SHORT-TERM (30-DAY)

An individual may be admitted from home without the required IPAS assessment:

a) for a short-term stay not to exceed thirty (30) days;
b) with an expressed intent by the applicant or his or her representative to leave the NF within the authorized time.

The IPAS agency designee must determine that it is probable that the individual will be discharged from the NF within thirty (30) days from the date of admission. The IPAS agency must collect sufficient information to be able to make this decision.

NOTE: Do NOT use Short-Term (30-Day) authorization for direct from hospital admissions. Persons in a hospital acute care bed can only use:

a) "IPAS Direct From Hospital" authorization;
b) "PASRR Exempted Hospital Discharge;"
c) full IPAS/PASRR assessment; or
d) IPAS (non-PASRR) refusal to participate in IPAS.

3.5.1 Time Frame

Short-Term (30-Day) admission are limited to a stay not to exceed thirty (30) days from the date of NF admission.

If approved, the IPAS agency designee will:
a) enter the approval on the original IPAS Application with the authorized time limit specified;
b) forward a copy to the NF; and
c) after the expiration of the authorized time limit, issue a PAS 4B specifying the type of approval and time limits.

No further action is required by the IPAS agency unless there is a change in the applicant's condition or situation.

3.5.1.1 Extension Beyond 30-Days

If the applicant's condition or situation changes such that NF placement is needed beyond the 30-day approved time, the applicant or NF (acting on the individual's behalf) must, PRIOR to the expiration of the approved time:
a) notify the IPAS agency;
b) in writing;
c) requesting an extension of the authorized time; and
d) include an explanation of the change which now necessitates additional care in the NF specifying:
   1) whether additional short-term care or long-term care is now needed; and
   2) if short-term, the anticipated number of days needed.

3.5.1.2 Extension Authorization

"Short-Term (30-Day)" authorization may be extended for no more than twenty-five (25) days additional days (maximum 55 days).

The IPAS agency will:
a) decide whether extended placement should be authorized;
b) record the decision on the original IPAS Application form;
c) initial and date the notation; and
d) provide a copy to the applicant and the NF.

A copy of the NF request letter and the updated IPAS Application form must be included in the IPAS case record.

If extended stay is approved, the IPAS agency will:
a) conduct the complete IPAS assessment;
b) process the case for final determination' and
c) if it is a non-Medicaid case, issue the PAS 4B specifying that the original admission was for Short-Term 30-Day, extended to a given date.

The IPAS assessment may result in a decision/recommendation on the PAS Form 4A or 4B to:
a) approve NF placement for an:
   1) extended but time-limited placement; or
   2) for long-term placement; or

b) deny continued NF placement.

3.5.2 Definitions

The IPAS agency should be aware of the following considerations.
a) "Short recuperative care" is a temporary service by which care is provided to assist an individual to regain the minimum level of independent functioning. Such care may be needed due to malnutrition, need for temporary diabetic diet monitoring or insulin adjustment, medication adjustment or monitoring, or other short-term medical need. The need for care will be documented in the IPAS case record.

b) "Respite care" is a temporary or periodic service by which care is provided to a functionally impaired individual for the purpose of relieving the regular, unpaid

caregiver. Non-Medicaid individuals may utilize the short-term 30-day stay for respite purposes.

For Medicaid purposes, the term “respite” should only be applied to Medicaid applicants admitted under PASRR’s Categorical Determination for Respite Care (See Chapter 13.6.1.) or Medicaid A&D or MFC Waiver Respite Care (See Chapter 7.). To avoid confusion, the IPAS agency should always refer to eligibility under this criteria as a “Short-Term or (30-Day)” admission and avoid use of the term, “respite.”

However, if medical need for NF level of services is present and shown in the record, Medicaid eligible individuals may use the Short-Term (30-Day) for a short stay. It is Medicaid’s decision whether Medicaid will reimburse for the NF stay. Under these circumstances, the IPAS agency should clearly document this purpose on the IPAS Application form or an attachment.

c) The "Short-Term (30-Day)" provision may also be used for transfers within a CCRC when the individual is anticipated to need a stay which will be more than 5-days in length. No more than 30-days may be approved for the Short-Term 30-Day stay. (See Chapter 3.6.)

3.6 FIVE-DAY TRANSFER WITHIN A CCRC

A non-PASRR individual may be transferred into a NF bed for a short-term stay (five days or less) within a Continuing Care Retirement Center (CCRC) without applying for IPAS or receiving designee-approval.

NOTE: The individual must be a current resident of the same CCRC in which the transfer is occurring. The “Five-Day Transfer Within a CCRC” cannot be used for admission of an individual from an outside living arrangement.

Prior to using this provision, a Medicaid-certified NF must complete a new Level I form to determine and document current PASRR status. If Level II is required, the PASRR admission requirements must be followed and the Five-Day Transfer provision cannot be used. (See Chapters 10-16 of this Manual.)

3.6.1 Time Frame

A short recuperative or respite stay not to exceed five (5) days is exempted from the IPAS requirement for the five (5) day period only.

3.6.2 Extended Stay Request

The “Five-Day Transfer Within a CCRC” stay may be extended when the individual:
a) does not recuperate within the anticipated period (five days or less); or
b) the NF stay needs to be extended due to a change in circumstances.

The individual (or NF if designated by the individual) must immediately notify the IPAS agency:
a) explaining the need for extended stay;
b) giving the anticipated length of stay needed; and
c) obtain IPAS agency designee authorization.
Notification may be made by telephone, followed by a written notification.

NOTE: The Application form and Level I must be completed no later than the fifth (5^{th}) day following admission. These forms must be sent to the IPAS agency within five (5) working days.

3.6.3 IPAS Agency Designee Authorization

The IPAS agency designee may authorize up to an additional twenty-five (25) days, not to exceed thirty (30) days using the Short-Term 30-Day provision.

3.6.3.1 Extended Short-Term Stay

When it is anticipated that the applicant will need an additional stay of 30 days or less,

the IPAS agency will:

a) follow procedures for "Short-Term (30-Day) Admissions" (See Chapter 3.5);
b) certify authorization for temporary stay on the original IPAS Application form submitted by the NF; and
c) forwarded a copy to the NF to:
1) give to the applicant; and
2) maintain on the individual's active record/chart.

The case record will record the use of the "Five-Day Short-Term Transfer Within a CCRC" exclusion including the individual/NF's written explanation of need for longer stay.

3.6.3.2Long-Term Stay

The NF must notify the IPAS agency when the applicant's condition indicates need for long-term NF placement. The IPAS agency will:

a) extend the authorization for placement using the "Short-Term 30-Day" provision as above; and
b) will immediately begin full IPAS assessment following regular IPAS procedures.

3.7 DIRECT FROM HOSPITAL

To expedite timely hospital transfer of individuals who need the level of care provided in a NF, a hospital discharge planner may be appointed to authorize temporary placement into a NF under specific conditions.

NOTE: For transfers from a hospital emergency room (ER), hospital 23-hour holding unit, or "after hours" discharges, see Chapter 3.5.4, Emergency/APS Admissions.

3.7.1 Basis of "Direct from Hospital"

The "Direct from Hospital" authorization is allowed based on a presumption that:
a) an individual receiving acute level of care in a hospital will have at least minimal NF level of services need;
b) for at least a short period of time, during which the full IPAS assessment is completed.

A "substantially complete assessment" is required to establish temporary need for NF level of services. (See Chapters 3.3.3 and 4.3.1.)

3.7.2 Appointment of "Hospital Discharge Planner" Designee

The IPAS agency may:
a) execute a written agreement between the hospital and the IPAS agency, subject to approval by BAIHS, for the hospital discharge planner designee activity; (See Appendix D1.) and
b) appoint the hospital discharge planner(s) to act as an IPAS designee for discharge from an acute-care hospital bed only.

NOTE: "Direct From Hospital" authorization does not apply to transfers between hospital NF units, subacute or non-acute care placements.

Discharge planners must:
a) complete an IPAS training on the duties and function of an IPAS designee; and
b) be certified by the IPAS agency PRIOR to acting as an IPAS designee.

Failure to follow requirements could result in revocation of an individual's appointment as IPAS designee or in loss of the hospital's designee activity status.

NOTE: In certain circumstances, the authorized IPAS agency representative will act as designee for requests for NF admission from the hospital's ER or 23-hour bed hold (Chapter 3.4.4) and hospital-based nursing (NF) units (Chapter 3.7.8).

3.7.3 Procedures for "Direct from Hospital"

Hospital discharge planning is the act of identifying patient needs and preparing for an effective, efficient and timely discharge of the patient. It includes linking patients with

appropriate services (facility-based and/or community-based) when they are discharged.

"The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will begin on the day of admission to the hospital." (42 CFR 483.43) (See Appendix J.)

IPAS is to be coordinated with this process.

3.7.3.1 Completion of "Level I"

Level I should always be completed prior to completion of the IPAS Application form to identify whether "Direct from Hospital" authorization can be used. Follow the steps diagrammed in Chapter 3.1.

3.7.3.2 Completion of IPAS Application Form

The IPAS Application form may be completed:
a) at the admitting NF; and/or
b) at the discharging hospital.

- If completed at the hospital, the entire Application form or only a portion may be done. When it is partially completed, the hospital must assure that:
  a) the following information is entered at a minimum:
     1) the applicant's name;
     2) home address;
     3) identifying information including Social Security number; and
     4) date of birth; and
     5) name and address of anticipated NF;
  b) the applicant and/or family is advised to contact the NF to complete the Application form; and
  c) a copy of the partially completed Application form is immediately forwarded to the admitting NF.

  Incomplete portions of the IPAS Application form must be completed at the NF within 24 hours of admission for "Direct from Hospital" authorized admissions.

NOTE: Completion of the "agree/do not agree" and "authorization for release of information" portions are optional at the hospital. However, an individual who:

a) is admitted to a NF under hospital discharge planner authorization;
b) but "refuses to participate" after completion of the IPAS Application form at the NF;
will be ineligible for Medicaid reimbursement, if needed, and will incur the IPAS penalty.

The Application form must be completed within twenty-four (24) hours of designee-authorized NF admission and forwarded to the IPAS agency.

- The hospital discharge planner records his or her authorization:
  a) on the IPAS Application form in "Section II: Temporary Admission Authorization," "Direct from Hospital;"
  b) PRIOR to transfer to the NF;
  c) by checking appropriate boxes, entering applicable time frames, signing and dating the form. (Start date is the date of NF admission)

"Direct From Hospital" authorization is only valid when Section II is appropriately completed.

- The hospital discharge planner must also check applicable statements in Section II that are listed directly below the “Types of admission.”
  a) Medicaid MCO enrollee: If the applicant is enrolled in a Medicaid MCO, check the box to so designate and check the appropriate box for “Short-Term” or “Long-Term” anticipated NF stay. If MCO does not apply, leave the boxes blank.
  b) Nonresident statement: Only check the second statement if the applicant is:
     1) a nonresident in an Indiana hospital who:
     2) received treatment in the Indiana hospital’s emergency room (ER); and
     3) was directly admitted and received treatment in the Indiana hospital’s acute care bed. (See Chapter 3.9.2.)

c) List of Long-Term Care Services: Check the box if the Indiana hospital has given to every patient who will be participating in IPAS:

1) the required list of long term care options;
2) available to the applicant;
3) located within the hospital’s service area; and
4) known to the hospital.

- The discharge planner who completes the authorization must sign, date, enter the name and location of the hospital with which he/she is affiliated, phone number, and fax number.

  Either the NF and/or the hospital must forward it to the IPAS agency. The admitting NF has the responsibility to assure that the Application form is fully completed and that a copy is forwarded to the IPAS agency within five (5) working days.

  The hospital must assure that the NF receives the original of the fully or partially completed Application form. To expedite an assessment, which must be completed prior to hospital discharge, the hospital may also send or fax a copy of the fully completed Application form to the local IPAS agency.

- When the individual refuses to participate in IPAS while in the hospital, the hospital discharge planner CANNOT authorize NF admission. The IPAS Application “refuse to participate” portion must be completed. If the individual is admitted to a NF, he or she will incur the IPAS penalty. (See Chapter 6.2.)

3.7.3.3 Time Frame

"Direct From Hospital" admissions may be authorized for varying lengths of stay, judged on:
a) the attending physician’s estimated time of recovery (ETR); and/or
b) the individual's Medicaid status.

Time frames are calculated from the date of NF admission.

a) Medicaid Recipients, Applicants, or Will-Apply (within 120 days): NF placement may only be authorized for a maximum of twenty-five (25) days for individuals who are Medicaid applicants, recipients, or will apply, regardless of presumed Medicare or other payment status.
b) Private-Pay Applicants (Non-Medicaid): NF placement may be authorized for the physician's Estimated Time of Recovery (ETR) plus twenty-five (25) days, not to exceed a maximum of one-hundred twenty (120) days.

The physician’s ETR is the needed length of NF care designated by the physician. It will be based on the individual's level of functional impairment and prognosis for improvement.

3.7.4 Arrangement for NF Admission

The hospital discharge planner must provide necessary information for the NF to make an admission decision when the hospital discharge planner contacts the NF to arrange for a bed.

The NF must have sufficient information about the individual's condition and history to determine the patient's status and whether it (NF) can meet the individual's needs. This would normally include answers to questions about: diagnosis, medications, ADL impairments and need for care, suicidal or homicidal ideations and/or behavior problems, prior residence of individual, responses on Level I form and whether answers are correct, and any other information which may affect the NF's ability to meet the individual's needs.

3.7.5 Transmission of Documents to NF

All necessary hospital-completed IPAS and/or PASRR documentation must accompany the individual or be transmitted to the NF prior to admission. The NF must assure that all necessary documentation has been completed and placed on the individual's active record/chart.

3.7.6 IPAS Agency Acting As "Direct From Hospital" Designee

The IPAS agency will act as IPAS designee when:

a) a hospital refuses to exercise the option of acting as IPAS designee;
b) IPAS designee-status has been revoked; or
c) discharge is needed from a hospital-licensed (IC 16-21) hospital-based NF unit following a "substantially complete assessment."

Either the NF or the hospital may make referral for assessment directly to the IPAS agency.

Since the IPAS agency designee is not familiar with the individual or his or her needs, a "substantially complete assessment" is required. (See Chapter 4.3.1.) The IPAS agency must obtain enough information to perform the assessment which will require more time and review than the discharge planner's process.

3.7.7 Required NF Follow-Up

For "Direct From Hospital" admissions, the NF must assure that it:

a) receives the necessary paperwork from the hospital or from the IPAS agency, as appropriate;
b) reviews documentation (Application form, Level I, and so forth) for completeness PRIOR to forwarding it to the IPAS agency;
c) sends all necessary documents to the local IPAS agency (or assures that it has been sent by the hospital within 5 working days from the date of signature or, if the individual is admitted, from the date of admission, whichever is later; and
d) retains a copy of all documentation on the NF chart/file.

3.8 HOSPITAL-BASED NF UNITS

Some hospitals have hospital-based long-term care (NF) units. These units provide skilled (NF) level of nursing care and are located within the hospital. Such units may be called Extended Care Units (ECU), Transitional Care Units (TCU), Essential Care Services (ECS), or another label to differentiate them from acute care hospital beds.

SURVEY: These units are subject to survey by the ISDOH Long-Term Care Services Division, and must meet all NF criteria regardless of how they are licensed.

LICENSURE: Depending on factors such as who administers the unit, they may be licensed under either hospital licensure (IC 16-21) or NF licensure (IC 16-28).

In order to determine the relationship to IPAS and/or PASRR laws and regulations for these units, licensure and Medicaid certification status of each unit must first be determined.

3.8.1 IPAS Participation Requirement

IPAS law requires that hospital-based NF beds licensed under IC 16-28 must participate in IPAS for admissions and discharges.

To determine whether IPAS requirements apply, the licensure status of the hospital based NF unit must be established. The IPAS agency should:

a) check with the hospital unit; or
b) review the "Indiana Health Facilities Directory" published by the Division of Long-Term Care, Indiana State Department of Health (ISDH); or
c) call the ISDH, Division of Long-Term Care.

3.8.2 PASRR Participation Requirement

PASRR regulations require all Medicaid certified NF beds to participate. If the unit is Medicaid certified, it must follow PASRR requirements regardless of whether it is currently serving any Medicaid recipients or receiving Medicaid reimbursement. (See Chapter 10.3.) State licensure status is not a factor.

NOTE: The IPAS agency will log and update the status of hospital-based NF units in its area regarding IPAS and/or PASRR participation. (See the log in Appendix D, available on diskette from the State PASRR Unit.)

3.8.3 Differentiation between "Hospital-Licensed" and "NF-Licensed"

IC 12-10-12-3 specifies that IPAS applies to a nursing facility that is licensed under IC 16-28. by Therefore, a distinction must be made between hospital-based NF units with hospital licensure under IC 16-21 and those NF-licensure under IC 16-28.

The simplest method to determine how a hospital-based NF unit is licensed is to refer to listings in the Indiana Health Facility Directory published by the Indiana State Department of Health (ISDOH), Long-Term Care Program. "Hospital-licensed" units are listed at the back of the directory under the title page, "Hospital Based Long Term Care Units," usually around page 60. "NF-licensed" hospital-based NF units will be listed in the first part of the directory with NFs that are not hospital-based.

This differentiation is based not on survey activities, as all NF units must meet the same survey criteria. It is instead based on criteria established by the ISDOH entity which issues the license: either the Long Term Care Program (NF) or the Acute Care Division (hospital).

NOTE: The following criteria also apply to hospital-based NF units:
a) If the Unit is Medicaid-certified, Level I must be completed to determine PASRR status PRIOR to admission to the hospital's NF unit.
   (Then, if PASRR Level II is required, all IPAS and PASRR requirements for an individual needing PASRR Level II apply for the admission into the hospital-based NF unit.)
b) PASRR "Exempted Hospital Discharge" can only be used to authorize transfer from an acute care bed into a skilled (NF) care bed.

3.8.4 "Hospital-Licensed" (IC 16-21) Hospital-Based NF Unit

Admissions must follow requirements under the respective programs (IPAS and/or PASRR) which apply to the hospital-based NF unit.

♦ Admission: Admission to these units should use the following critera:

a) IPAS-only (non-PASRR) admissions do not require IPAS designee authorization (However, these units may voluntarily participate in IPAS, if desired, for expeditious discharge to another NF.); or

b) if PASRR is needed, only with "Exempted Hospital Discharge;" or
c) with full IPAS/PASRR assessment and determination made PRIOR to admission.

♦ Discharge: The patient may be transferred to a NF bed licensed under IC 16-28:
a) by using the time remaining on a Direct-from Hospital authorization made while in an inpatient acute care hospital bed*; or
b) with PRIOR completion of the IPAS assessment and determination by the IPAS agency.
*NOTE: The hospital discharge planner cannot give Direct-from Hospital authorization after the individual has been admitted to the hospital-based NF unit.

3.8.5 "NF-Licensed" (IC 16-28) Hospital-Based NF Unit

A hospital-based NF-licensed unit must follow the same procedures as a freestanding NF.

- Admission: Admissions to these units may only be made:
  a) under IPAS-Only (non-PASRR) "Direct From Hospital" authorization made while the patient is in the acute care hospital bed; or
  b) if PASRR Level II is needed, under "Exempted Hospital Discharge;" or
  c) with full IPAS/PASRR determination.

  NOTE: PASRR Exempted Hospital Discharge is only allowed for transfer from "acute inpatient care."

- Discharge to another NF Direct transfer to another NF licensed under IC 16-28 may be made when the following conditions are met:
  a) PAS 4B has been issued for full IPAS and, if applicable, PASRR, assessment; or
  b) authorized time remains from a "Direct from Hospital" authorization made while the patient was in the hospital's acute care bed.

  The IPAS agency may find the table at Appendix D helpful when recording the status of the hospital-based NF units for the hospitals in its area.

3.8.5 Hospital "Medicare Swing Beds"

Medicare "Hospital Swing Beds" are hospital-based SNF level beds for post-hospital extended care services which meet the following criteria. The hospital:

a) is small, having less than 100 beds, excluding certain categories;
b) is in a "rural" area, not delineated as an "urbanized" area by the Census Bureau;
c) has a certificate of need for the provision of long-term care services from the ISDOH;
d) does not have in effect a 24-hour nursing waiver;
e) has not had a "swing-bed" approval terminated within 2 years prior to application;
f) a Medicare-participating SNF is not available or it has agreement with SNFs in its area which meet certain criteria; and
g) gives HCFA written assurance that it will not operate over 49 beds or over 99 beds except in connection with a catastrophic event. (Paraphrased from 42 CFR 482.66.)

3.8.5.1 "Swing Beds" and IPAS/PASRR

For IPAS and PASRR processing purposes, hospital Medicare Swing Beds will be treated as acute care beds.

IPAS bases its requirement for participation on licensure status. Swing Beds are hospital-licensed by the Acute Care Division at ISDOH. For PASRR, HCFA has only issued a statement that it was studying the application of PASRR requirements to swing beds. To date, Swing Bed regulations have not been modified to reflect PASRR.

The determination is that, at this time, neither IPAS nor PASRR are required for admission to Medicare Swing Beds. Discharge will follow hospital acute care criteria for IPAS and PASRR.

3.8.5.2 Identification of "Swing Bed" Status

To establish the Medicare "Swing Bed" status of a hospital-based unit, the IPAS agency should:

a) ask the hospital whether Medicare has approved it to provide post-hospital extended care services as specified under 42 CFR 409.30, and is it reimbursed as a swing-bed hospital as specified under 42 CFR 413.114;
b) ask the hospital if they are able to bill Medicare for these beds as "swing beds;"
c) refer to the Indiana Health Facilities Directory for a listing (Check both sections: if the hospital is not listed in either section and its unit has been operational for more than a year, it may be assumed that the unit qualifies as a "swing-bed." For example, Decatur County Hospital has a "swing bed" unit.); and
d) if still in doubt or unable to verify, call the Acute Care Division at ISDOH.

3.9 NONRESIDENTS

All out-of-state residents seeking admission to an Indiana NF must complete the entire IPAS assessment and receive the determination PRIOR to admission to the Indiana NF, except as specified in Chapters 3.9.2 and 3.9.3.

NOTE: DO NOT APPLY THE FOLLOWING CRITERIA IF THE APPLICANT REQUIRES PASRR LEVEL II ASSESSMENT, EXCEPT AS SPECIFIED IN CHAPTER 3.8.4. (See Chapters 10-16 for PASRR.)

3.9.1 Time Frame

ALL nonresident, IPAS-only (non-PASRR), applications must be completed within ten (10) calendar days following the appointment of the IPAS screening team.

Nonresident case processing time frames are calculated:
a. from the date that the IPAS screening team is appointed
b. to the date that the IPAS agency reports its findings.

For tracking purposes, the IPAS agency will
a) document the date that the IPAS screening team is appointed;
b) stamp all case documents with the required "date-received;" and
c) clearly explain in the case record the reason(s) for any delays, including all appropriate tracking dates.

The "date that the IPAS agency reports its findings" is defined to mean either:
a. the date that the IPAS agency issues its determination on PAS Form 4B for private-pay applicants; or
b. the date that the IPAS agency faxes the case with its recommendation on PAS Form 4A to OMPP or the State PASRR Unit.

It is important for the IPAS agency to record these dates on either the PAS Form 4A or 4B. A record of these dates and delays may be pertinent to appeals and/or waiver of the IPAS penalty requests.

3.9.2 Refusal to Participate in IPAS

A nonresident who does not require Level II may:
a) refuse to participate in IPAS;
b) be admitted to an Indiana NF; and
c) incur the IPAS penalty.

NOTE: The IPAS agency must obtain as much documentation as possible to support a decision that PASRR Level II is not required. The Level I completion will usually not be enough. The case record must describe in detail the efforts and results to verify that PASRR Level II is not needed.

3.9.3 Nonresidents and Indiana NF Temporary Admissions

An IPAS agency cannot authorize temporary admission to an Indiana NF except under Chapter 3.9.4.
PRIOR to authorizing a temporary admission a full lPAS assessment and determination must be completed.

- After the full IPAS assessment and determination are completed and admission under IPAS approved, the IPAS agency may authorize IPAS "30-Day Short-Term."
- After the full IPAS and PASRR assessment and determination are completed and NF admission approved, the IPAS agency may authorize PASRR "Exempted Hospital Discharge" (unless the

provision in 3.9.2, above, is used), or PASRR “Respite.”

As soon as it is found during the temporary stay that the individual’s condition/circumstances have changed so that he or she now requires a longer NF stay:
a) the NF must immediately notify the IPAS agency;
b) a verbal notice from the NF must be followed by a written explanation to the IPAS agency fully explaining the nature of the change which now makes long-term placement necessary;
c) the PASRR Level II must be updated, if required due to a change in MI and/or MR/DD condition, following instructions in Chapter 13; and
d) the IPAS agency will update the IPAS case packet and redo the IPAS determination, as applicable.

The IPAS agency may recommend:
a) an extension of the short stay; or
b) if warranted, long-term placement.

3.9.4 "Indiana Resident" in an Out-of-State Hospital

An Indiana resident seeking admission to an Indiana NF from an out-of-state hospital qualifies for authorization for “Direct from Hospital” admission if the Indiana resident:
a. is participating in IPAS; and
b. has received treatment in the acute care bed of the out-of-state hospital; and
c. is being discharged directly from the hospital into an Indiana NF; and
d. has received authorization by the IPAS agency designee.

NOTE: An out-of-state hospital discharge planner CANNOT authorize admission to an Indiana NF under any circumstances.

3.9.5 Nonresidents in an Indiana Acute Care (Hospital) Bed Following Treatment in the Indiana Hospital’s ER

A change in Indiana law effective July 1, 1997 allows a nonresident to be admitted to an Indiana NF directly from the Indiana hospital under the following circumstances:
a. the nonresident received treatment in an Indiana hospital’s emergency room (ER);
b. the nonresident was admitted to the Indiana hospital acute care bed after receiving treatment in the Indiana hospital’s emergency room (ER); and
c. the applicant received treatment from and is being directly discharged from the Indiana hospital’s acute care bed; and
d. the applicant is participating in IPAS.

The IPAS agency or Indiana hospital discharge planner:
a) may authorize “direct from hospital” admission when the above conditions are met; and
b) must certify on the IPAS Application form, revised 1/98 or later, that the qualifying criteria applies by checking the appropriate statement below the check box for Direct from Hospital authorization.

NOTE: When an Application form is used which does not have the necessary certifying statement, the Indiana hospital discharge planner (or IPAS agency based on the information from the hospital discharge planner) will write the statement in Section II of the form.

To expedite processing, the hospital:
a) should begin discharge planning on the day an individual is admitted; and
b) may assist the IPAS agency by providing as much completed documentation as possible including, but not limited to:
   1) completion of the PASRR Level I and IPAS Application forms;
   2) having the doctor complete and sign the Physician Certification for Long-Term Care Services (Form 450B); and
   3) helping in any other way feasible.

3.9.6 Other IPAS Agency Requirements

For Medicaid data purposes, the IPAS agency must:
a. always inquire and record in the case record the reason a non-resident desires to enter an Indiana NF; and

b. maintain a log system identifying applications by out-of-state residents, including at a minimum: the original state of residence; Medicaid status in the other state; intended Medicaid status in Indiana; reason for seeking NF placement in Indiana; and case disposition.

When the applicant is in a NF out-of-state, the IPAS agency must obtain 30 days of the most recent NF chart information, including copies of nurses' notes, physician's orders and progress notes, and social service notes as part of the IPAS assessment.

3.9.7 Residency Determination

For purposes of the IPAS program only, an individual is considered an Indiana resident if he or she currently resides in Indiana or resided in Indiana immediately prior to hospitalization out-of-state. An Indiana resident seeking admission to an Indiana NF from an out-of-state hospital is treated as if he or she resides in Indiana.

HOSPITAL BASED NF UNITS
Chapter 3.8

—

Hospital-Based NF Unit

Hospital Licensed (IC 16-21)

Admissions

Non-IPAS (Non PASRR): May admit:
1. Without IPAS designee authorization; or
2. With final IPAS determination PRIOR to admit.

IPAS/PASRR (If Unit is Medicaid-certified as NF):
1. Amit under PASRR "Exempted Hosp Discharge;" or
2. With final IPAS/PASRR determination PRIOR to admit.

Discharges to Another NF

IPAS Only (Non-PASRR):
1. May use IPAS designee authorization made by IPAS agency for "Direct from Hospital"*; or
2. Final IPAS determination

IPAS/PASRR (Medicaid-Certified):
1. May use balance of "Exempted Hospital Discharge days to transfer; or
2. Need final IPAS/PASRR determination PRIOR to transfer.

NF Licensed (IC 28-2)

Admissions

IPAS Only (Non PASRR):
1. Must have IPAS "Direct from Hospital;" or
2. Needs final IPAS determination; or
3. Refuses IPAS (Admit with IPAS penalty)

IPAS/PASRR (If Unit is also Medicaid-certified as NF):
1. Admit under PASRR "Exempted Hospital Discharge;" or
2. With final IPAS/PASRR determination PRIOR to admit

NOTE: May NOT admit if refuses IPAS.)

Discharges to Another NF

IPAS Only (Non-PASRR):
1. May use balance of IPAS "Direct from Hospital" to transfer; or
2. With final IPAS determination (PAS 4B); or
3. Under IPAS penalty in admitting NF

IPAS/PASRR:
1. May use balance of "Exempted Hospital Discharge;" or
2. Need final IPAS/PASRR determination.

*Based on "Substantially Complete Assessment." (Chapter 4 3.1) For example, the IPAS agency may do the entire assessment to the point of submission to the State determination authority and, based on this documentation, conclude that temporary admission is appropriate. Written authorization and an explanation must be included in the case packet. NOTE: All IPAS/PASRR forms and documentation must be transferred to the admitting NF PRIOR to, but no later than, the date of admission.

This page is intentionally blank.

IPAS & PASRR MANUAL

Table of Contents

IPAS and Nonresident Admissions
(HEA 1223/IC 12-10-12)
Effective July 1, 1997

I. Nonresident At Home or Setting Other Than Hospital Inpatient	**II. Indiana Resident in Out-of-State Hospital**	**III. Nonresident in Out-of-State Hospital**	**IV. Non in I Hos**
IPAS/PASRR completed PRIOR to Indiana NF admission. BASIS: **Substantially-Complete Assessment issued.**	**IPAS agency designee may authorize "Direct from Hospital" if:** 1. **participating in IPAS;** 2. **received treatment in out-of-state hospital; and** 3. **being discharged directly from hospital to NF.**	**IPAS agency must complete full IPAS/PASRR assessment and determination PRIOR to Indiana NF admission.**	**Criteria under IC 12** 1. **Admitted to hos receiving treatme emergency departm** 2. **received treatm discharged from a acute care bed; a** 3. **participating i** **Yes, meets criteria.** **Indiana hospital discharge planner designee or IPAS agency designee may authorize "Direct from Hospital" admission with certification on IPAS Application that requirement met.**

Time Limit for Nonresident IPAS Assessments:
1. **Applies to ALL nonresident applicants;**
2. **IPAS agency has 10 calendar days to "report its findings;**
3. **Beginning date is the date the IPAS team is appointed; and**
4. **Ending date is date IPAS agency:**
   a. **issues its PAS 4B for private-pay applicants; or**
   b. **faxes the case and recommendation on PAS 4A to OMPP or the State PASRR Unit.**

THIS PAGE IS INTENTIONALLY BLANK.

Chapter 4

IPAS ASSESSMENT

The purpose of the IPAS assessment is to determine:
(1) the appropriateness of an individual's placement in a NF;
(2) whether community-based services are available which would meet the individual's needs; and
(3) a cost-comparison analysis of community-based versus NF care.

4.1 IPAS SCREENING TEAM

A screening team consisting of at least two (2) members for each applicant conducts the IPAS assessment. It must include:
a) the applicant's attending physician will participate as a member of the team.
b) the IPAS agency, subject to approval by the State, will appoint an individual who:
   1) represents the IPAS agency serving the area in which the applicant's residence is located; and
   2) is familiar with personal care assessment; and
   3) meets the qualifications specified at 460 IAC 1-1-10(c) or (d). (See Appendix ___.)

   The IPAS agency will assure that each appointee meets these requirements and will maintain documentation of the qualifications for State audit purposes. One approved individual will be appointed to be the Screening Team Coordinator.

c) Additional team members:
   1) may be appointed to the Team, if the IPAS Team Coordinator deems it necessary;
   2) should either meet the requirements above; or
   3) be able to provide specialized knowledge pertinent to the assessment of an individual's needs for IPAS purposes.

As the Team has the responsibility to act in a timely manner, and members of the Team may vary with each applicant, the Team will of necessity function as an informal unit

NOTE: The IPAS assessment and determination will be completed as soon as possible, but no later than twenty-five (25) days from the date of application, unless a different time frame applies for temporary admissions. (See Chapter 3.)

4.1.1 Appointment

The Team will be appointed by the IPAS agency that serves the county in which the applicant resides at the time the complete IPAS assessment is conducted. When an applicant resides out of state, the team will be appointed by the IPAS agency that serves the county in which the anticipated NF is located.

More than one (1) team per area may be appointed.

4.1.2 Duties

The IPAS Team will conduct the IPAS assessment according to the policies and procedures prescribed by DDARS. (See Chapters 4.2, 4.3, 4.4 and 4.5.)

After the IPAS assessment is completed, the members of the IPAS Team will review all case documentation. The IPAS Team will vote:
a) on whether NF placement is appropriate according to IPAS (and, if required, PASRR) criteria, using criteria consistent with Medicaid requirements;
b) either by signature at the time of individual team member contact, or by telephone;
c) using the physician team member's completion of and signature on the Form 450B, unless he/she wishes to be more active in IPAS Team activities.

Assessment

Conducted by IPAS Screening Team Members:

Applicant's Physician	IPAS Agency Team Coordinator	Other (Appointed by IPAS Team Coordinator)

IPAS Assessment:

- Eligibility Screen
- Physician Certification for Long-Term Care Services (450B)
- Level II (If required)
- Other Documentation
- Plan of Care/Cost Comparison

Report of Findings:

IPAS Agency Final Determination on Form PAS 4B		IPAS Agency Recommendation on Form PAS 4A
Private-Pay: Approvals Only	PASRR Level II: All cases (Including Denials, Inappropriate Referrals, Depression Screen and Marginal Level of Care Cases) State PASRR Unit Issues Form PAS 4B	• Medicaid Recipient • Medicaid Pending/Applicant • Medicaid Will Apply • Denials (Incl. Private-Pay) • Marginal Level of Care (Incl. Private-Pay) OMPP Issues Form PAS 4B

—

4.1.3 Submission of Findings

The findings and recommendation of the IPAS Team will be recorded on the PAS Form 4A, Recommendation of Screening Team. (See Chapter 4.6.)

The recommendation on the PAS 4A form will be:

a) considered to be for "long-term placement;"
b) unless a time-limited "short-term" stay approval is indicated that specifies the applicable time period; and/or
c) modifies the stay by indicating that a follow-up assessment should be done after a specified length of time.

4.2 CONDUCTING THE ASSESSMENT

The IPAS agency will follow accepted standards of case assessment, incorporating factors pertinent to the IPAS program.

4.2.1 Personal Interview/Visit with Applicant

A face-to-face visit with the applicant:

a) is always required;
b) unless the applicant is currently residing out-of-state; and.
c) results of the visit will be adequately recorded in the case record.

(Nonresident applicants currently in an Indiana hospital, however, must be visited as part of the assessment.)

4.2.2 Nonresident Applicants

The assessment of an applicant who is living out-of-state may be conducted via telephone. The IPAS assessor will speak with:

a) the applicant and/or guardian (whenever possible); and
b) persons knowledgeable about the applicant's condition and situation, including family members and/or interested persons;
c) persons in medical and/or other significant support positions; and
d) other persons in pertinent roles.

Information obtained via telephone will be documented and specifically identified, noting that it was received over the telephone. The relationship of the respondent to the applicant must be noted.

NOTE: The IPAS agency will clearly record in the IPAS case the reason for the request to move to an Indiana NF. This data will be maintained at the IPAS agency and reports filed with the State authority(ies), as requested.

4.3 CONTENT OF ASSESSMENT

The IPAS assessment:

a) is a comprehensive evaluation of an individual's short and/or long-term medical care and psycho-social needs;
b) culminates in a judgment of the appropriateness of short or long-term NF placement; and
c) makes a judgment whether NF placement can be offset by the availability of alternative community-based services to meet identified needs.

The IPAS assessor will record:

a) pertinent information and impressions from the interview, including the physical environment when an at-home assessment is conducted;
b) barriers to continued at-home placement;
c) information elicited from other individuals familiar with the applicant and his or her needs, identifying all sources of information; and
d) the applicant's condition at the interview on the Eligibility Screen when the applicant is unable to respond or cooperate with the interview.

If the applicant is in a hospital, NF, or out-of-state, questions should be phrased so that responses will reflect what the applicant's needs would be if he or she were at home or in a residential living environment.

NOTE: Do not state that a need is met because the hospital or NF provides the care. This is redundant.

Two (2) types of assessment are specified in the IPAS law:

a) a "substantially complete assessment" is a partial assessment process which collects sufficient information on the medical and psycho-social needs of the individual to determine that, prior to a final determination, temporary NF placement is appropriate; NOTE: It is used for "Direct from Hospital" designee authorization. (See Chapter 3.7.1.)
b) a "complete assessment" is a full assessment which culminates in a final determination of the appropriateness of NF admission for either short or long-term placement.

4.3.1 "Substantially-Complete Assessment"

IC 12-10-12-28 allows admission of a non-PASARR Indiana resident directly to a NF from acute (non-psychiatric) care in an Indiana licensed hospital under the following circumstances:

a) a substantially complete assessment has been completed; and
b) based on the assessment results, the IPAS designee makes a finding that services necessary to care for the individual outside the hospital are not at that time available except in a NF, at least for a short-term.

The “substantially complete assessment” must contain enough medical, psycho-social, functional impairment, and related needs information to make a judgment that at least temporary NF placement is needed.

Either the hospital discharge planner or the IPAS agency may act as designee for Direct-from-Hospital authorizations.

4.3.1.1 Hospital Discharge Planner Designee

Completion of the requirements under 42 CFR 482.43 assures that the hospital discharge planner meets the IPAS requirements for a “substantially complete assessment.”

For "Direct from Hospital" authorizations, the IPAS agency may appoint the hospital discharge planner(s) to act as IPAS designee:
a) following procedures in Chapter 3.7; and
b) based on the hospital discharge planning evaluation required by 42 CFR 482.43 used to constitute the “substantially complete IPAS assessment;” (See Appendix J.) and
c) including a copy of the applicable discharge planning evaluation in the patient's medical record transferred to the NF with the patient.

The results of the hospital's evaluation will be reviewed by the NF and used for the individual's NF plan of care. The IPAS assessor should also review it when a complete IPAS assessment is subsequently conducted.

4.3.1.2 IPAS Agency Designee

If the IPAS agency is acting as designee for "Direct from Hospital" authorizations (Chapter 3.7.6), the IPAS agency's designee will need to:
a) obtain sufficient information to constitute a “substantially-complete IPAS assessment” (Chapter 4.3.1) on which to base the decision for NF temporary placement, reviewing the hospital’s discharge planning evaluation as part of the decision-making; and
b) make a decision to authorize "Direct-from-hospital" temporary admission prior to submission of the IPAS case packet to the OMPP for final determination, if the individual is Medicaid and non-PASRR; or
c) do a complete IPAS assessment and make a final determination, when the individual is private-pay non-PASRR.

4.3.2 "Complete Assessment”

The assessment will be conducted using assessment forms developed and approved by DDARS. A complete IPAS assessment will, at a minimum, consist of the following:
a) demographic information necessary to identify the individual and his or her situation;
b) documentation of the current overall medical/physical and mental health condition of the individual;
c) information on the current psychosocial and related service needs of the individual;
d) evaluation of the individual's current degree of functional impairment and related service needs (based on performance of ADLs and the ability to perform ADLs, not the refusal to perform them);
e) identification of the current unmet necessary service needs of the individual which, if they continue to be unmet, would result in placement in a NF;
f) identification of formal and informal necessary services that are presently available to meet identified unmet service needs, listing both those currently being utilized and those not currently used or provided to the individual;
g) record of IPAS assessor's observations during the on-site visit;
h) record of other persons consulted during the assessment, including pertinent observations;
i) documentation of the individual's preference of care, regardless of agreement to enter the NF; and
j) construction of an IPAS care plan which includes cost comparisons.

Documentation may be drawn from various sources, including the physician, family, hospital discharge planner, case manager, and other care/service providers. The IPAS Team will collate all pertinent documentation as part of an IPAS case packet.

4.4 FORMS TO RECORD ASSESSMENT AND TEAM ACTION

The following IPAS forms, at a minimum, will be used to document the assessment findings of the IPAS Team:

a) certification of the need for PASRR Level II on the PASARR Level I, Identification Evaluation Criteria (State Form 45277/Form 450B Sect. IV-V);
b) authorization of temporary NF admission on the Application for Long-Term Care Services (State Form 45943/BAIS 0018);
c) documentation of medical need on the Form 450B, Physician Certification for Long-Term Care Services, Sect. I-III (State Form 38143);
d) if an MR/DD condition, documentation of additional medical information on the Physician Certification for Long-Term Care Services and Physical Examination for Level II (State Form 45278/ Form 450B, Section VI);
e) assessment of need for care and functional impairments on the Eligibility Screen, ASD 013 (State Form 45528);
f) if a mental illness condition, the PASRR-MI Level II Assessment of Mental Health (State Form 43064) or, if a condition of MR/DD, the PASRR/MR/DD Assessment
g) other (Other pertinent documentation); and
h) record of the IPAS Screening Team's vote on the PAS Form 4A, Recommendation of Screening Team (State Form 706).

4.5 CARE PLAN AND COST COMPARISON

The last part of the IPAS assessment is the formulation of a care plan and the required cost comparison between community-based services and NF services.

4.5.1 Care Plan

The Eligibility Screen and other assessment information should result in a comprehensive, individualized plan of care, functioning to identify necessary alternative services and to perform the cost comparison requirement of IC 12-10-12-19(2). The plan of care will:

a) record the service plan;
b) identify gaps in service;
c) record the quantity and cost of necessary formal and informal long-term care services (in-home, community-based and facility-based);
d) compute the cost comparison; and
e) compute the percentage by which community care costs exceed the cost of NF care.

The IPAS agency will assure that the care plan is appropriately documented in the IPAS case record.

For an individual who has first been determined to need the NF level of services, IC 12-10-12-19 stipulates that NF placement may not be denied if:

a) community services that would be more appropriate than care in a NF are not actually available; or
b) the cost of appropriate community services would exceed the cost of placement in a NF; or
c) the applicant who is a current recipient of Medicaid Waiver Services chooses to be admitted to a NF. (See Chapter 7.)

4.5.2 Cost Comparison Computation

In order to establish the IPAS cost comparison, the cost of necessary home and/or community-based services will be:

a) computed and compared to the cost of NF care;
b) compared to the cost of non-institutional care; and
c) information on the availability and cost of alternative services provided:
   1) to the individual and/or the representative for possible use; and
   2) to authorized entities involved in establishment and provision of alternative services.

4.5.3 Identification of Alternative Services

The IPAS agency should provide Information to the individual and/or appointed representative on available home and community-based services not being used, but identified during the IPAS assessment.

4.6 IPAS TEAM RECOMMENDATION ON FORM PAS 4A

After an IPAS assessment is complete, the IPAS Screening Team will make a formal recommendation of its findings. NOTE: The IPAS Screening Team makes a "recommendation" to the appropriate determination authority. This recommendation will not be construed to constitute the "final determination."

4.6.1 Review of Assessment Documentation

The IPAS Screening Team will perform the following functions:

a) review the IPAS assessment records and documentation; and
b) make a finding based on need for care including need for NF level of services (using Medicaid criteria); and
c) if there is a medical need for NF level of services, consider the availability of alternative home and/or community-based services to offset the need for a NF and compare the cost of alternative services to the cost of NF institutional care.

4.6.2 Recording the Vote

Following the case review, the IPAS Team will record the vote of each member of the IPAS Screening Team on form PAS 4A.

a) The vote may either be made by a signature at the time of individual contact, based on a review of all necessary IPAS data, or the vote may be conducted by telephone and recorded by the IPAS agency Coordinator.
b) Although the vote of the physician Team Member is made by completion of and signature on the Form 450B, the physician may opt at any time to participate more actively as a Team member.

The vote of the IPAS Screening Team constitutes a formal recommendation of the appropriateness of NF placement to the IPAS agency.

NOTE: The form PAS 4A also records other pertinent information or decisions which apply to the determination process such as:

a) recommendations for time-limited stays (including beginning and ending dates);
b) type of designee authorization or exclusions used;
c) Class A infractions;
d) IPAS penalty periods; and
e) other items significant to the determination process should be listed.

4.6.3 "NF Placement Is Inappropriate"

If the IPAS Team finds that placement in a NF should be denied, the recommendation on the PAS 4A form will:

a) list the reason(s) for denial, including but not limited to:
   1) does not have the need for the level of services provided in a NF; and/or
   2) needs specialized services identified through a PASRR Level II assessment; and
b) list identified, available alternative community-based services:
   1) detail the source/provider and cost of those community services, regardless of the source of payment; and
   2) detail the cost of placement in a NF (which will include the cost of all services, including those costs in addition to per diem which the applicant will require), regardless of the source of payment.

The assessor will:

a) discuss any alternative services identified in the course of the assessment with the applicant or his or her legal representative;
b) answer any questions involved with the IPAS assessment; and
c) put all findings in writing.

4.7 PREPARATION AND DISPOSITION OF CASE PACKET

The IPAS agency team member will:

a) prepare the contents of the case packet in the order specified below using documentation listed in Chapter 4.4;
b) submit the IPAS and/or PASARR Case Packet to the appropriate determination authority as soon as possible, but no later than five (5) days prior to the expiration of the designee authorized time limit;
   1) fax the IPAS-Only Medicaid recipient/applicant/will apply and denial/marginal case packet to the State OMPP;
   2) fax the PAS/PASRR (including Level II deferral and inappropriate) case packet to the State PASRR Unit for determination; and
   3) make the determination and issue the PAS 4B for private-pay/non-PASRR cases.

The IPAS agency will clearly explain the reason for any delays in meeting the required time frame in the case record. It should list the date of IPAS application, the type of IPAS case (from home or type of designee-authorized temporary admission), all applicable dates (including specific dates of designee-authorization) and a statement of circumstances causing the delay.. Cases pended beyond applicable time limits, without legitimate explanation of the delay, may be subject to post-audit penalty.

Order of documents in the IPAS/PASARR Case Packet, from top to bottom:
a) PAS Form 4A, Recommendation of Screening Team (State Form 706)
b) Form 450B, Physician Certification for Long-Term Care Services, Sect. I-III (State Form 38143)
c) (If MR/DD referral) Physician Certification for Long-Term Care Services and Physical Examination for Level II, Section VI (State Form 45278)
d) Form 450B, PASARR Level I, Identification Evaluation Criteria, Sect. IV-V (State Form 45277)
e) If PASARR, Assessment of Mental Health/PASARR-MI Level II or MR/DD Assessment (State Form 43064)
f) ASD 013 Eligibility Screen (State Form 45528)
g) Application for Long-Term Care Services (State Form 45943/BAIS 0018)

Chapter 5, IPAS Final Determination, describes the process, forms distribution, and other factors connected to the final determination.

NOTE: At the conclusion of the case, the IPAS agency will assure that Form 4B: Assessment Determination (State Form 707), along with the PASARR Certification Determination (State Form 47176/BAIS 0032) form, when applicable, is attached to the top of the case packet when the case is stored in its files.

IPAS & PASRR MANUAL

Table of Contents

This page is intentionally blank.

Chapter 5

IPAS FINAL DETERMINATION PROCESS

When the IPAS assessment and IPAS Screening Team recommendation are complete, a final determination of appropriateness for NF placement will be made.

5.1 FORM PAS 4B

EVERY RESIDENT OF AN INDIANA NF MUST HAVE A PAS FORM 4B ON THE NF CHART. The PAS Form 4B:
a) records the patient's status regarding IPAS compliance; and
b) proves that the NF complied with the IPAS law requirement in Chapter 2.3.1.

The form PAS 4B, Assessment Determination, records the final determination for the IPAS and/or PAS portion of the PASRR programs. (For PAS/PASRR, form PAS 4B is always used in conjunction with the PAS/PASRR Certification form.)

All pertinent information recorded on the form PAS 4A, Recommendation of Screening Teams, will be transferred to the PAS 4B by the determination authority, unless it does not apply.

A final determination is:
a) valid for 90 days from the date of issuance of the PAS Form 4B as long as:
   1) the individual has not been admitted to a NF; or
   2) his/her condition has not improved to the extent that NF admission is no longer needed;
b) valid for only one admission. THE 90-DAY ALLOWANCE EXPIRES WITH NF ADMISSION. A full or updated IPAS assessment must be done again if an individual who has been admitted to a NF leaves or is discharged to home and seeks readmission prior to the expiration of the 90 days,. (See Chapter 5.5.)

5.2 CASE TERMINATION PRIOR TO FINAL DETERMINATION

A case may be terminated prior to final determination by the local IPAS agency, the OMPP, or the State PASRR Unit. (Also see Chapter 2.6.4.)

Reasons for case termination include, but are not limited to, the following:
a) voluntary withdrawal by the applicant;
b) lack of cooperation by the applicant or legal representative;
c) death of the applicant;
d) discharge from the NF to home or living arrangement;
e) identification of an IPAS penalty which is still in effect;
f) concurrent IPAS case processing by another IPAS agency (See Chapter 2.4 and 3.1.); or
g) another appropriate reason.

The "NF discharge date" is the date on which the NF record is closed and/or the last date for which the NF may bill Medicaid.

NOTE: Never pend a case beyond applicable time limits because an individual cannot make a decision or has changed the decision to continue to seek NF placement. The case should be terminated due to voluntary withdrawal, refusal to participate, or failure to cooperate, as applicable.

An IPAS application should not be pended beyond applicable IPAS and/or PASRR processing time frames, unless the following applies:
a) the applicant has been discharged to an acute care hospital bed with the expectation that he or she will return to the NF following hospital discharge;
b) there is a "Medicaid 15-day bed hold" or a leave of absence during which the NF record is held open and the bed held for a patient's return; or
c) the physician, hospital, or NF fails to provide necessary documentation; or
d) another appropriate reason applies.

The IPAS agency will clearly document, on the PAS Form 4A, the reason an IPAS and/or PASRR case is pended, clarifying the applicable dates. When termination is due to voluntary withdrawal or

failure to cooperate, the individual should be advised that he or she can reapply. (Also see Chapter 5.6 for limits on reapplication.)

5.3 IPAS CASE REVIEW AND DETERMINATION PROCESS

The IPAS agency, OMPP or the State PASRR Unit makes final determination. The entity responsible for making the final case review and determination is based on the individual's status: private-pay, Medicaid eligible/applicant/will-apply, denial, marginal, or PASRR.

5.3.1 Non-PASRR Medicaid, All Denial and Marginal Cases

The State OMPP is responsible for final determination for non-PASRR:

a) Medicaid recipients, applicants, or will apply for Medicaid within 120 days;
b) denial cases; and
c) marginal cases on which the Screening Team disagrees or is unable to make a determination.

5.3.2 PASRR Cases

The State PASRR Unit is responsible for final determinations for all PASRR cases, regardless of other factors, including the following:

a) deferred cases;
b) Level II Inappropriate Referral cases. (Under certain conditions, the Inappropriate Referral form is used by the CMHC in lieu of completion of the Level II.)

Level II assessment may be deferred or delayed due to:

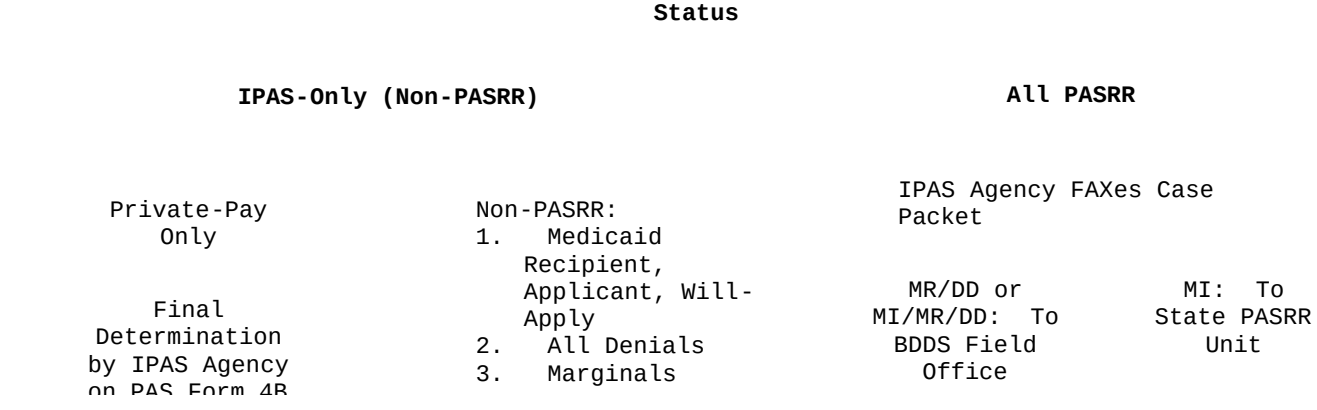
a) inability of the individual to cooperate in the assessment because of a state of delirium or coma; and
b) results of a Depression Screen which indicates that the depression has been both of short duration and mild intensity. When the IPAS agency uses the Depression Screen and does NOT make a referral for Level II, the IPAS agency will assure that the following caveat is entered on the PAS 4A form for transfer to the PAS Form 4B by the State PASRR Unit:

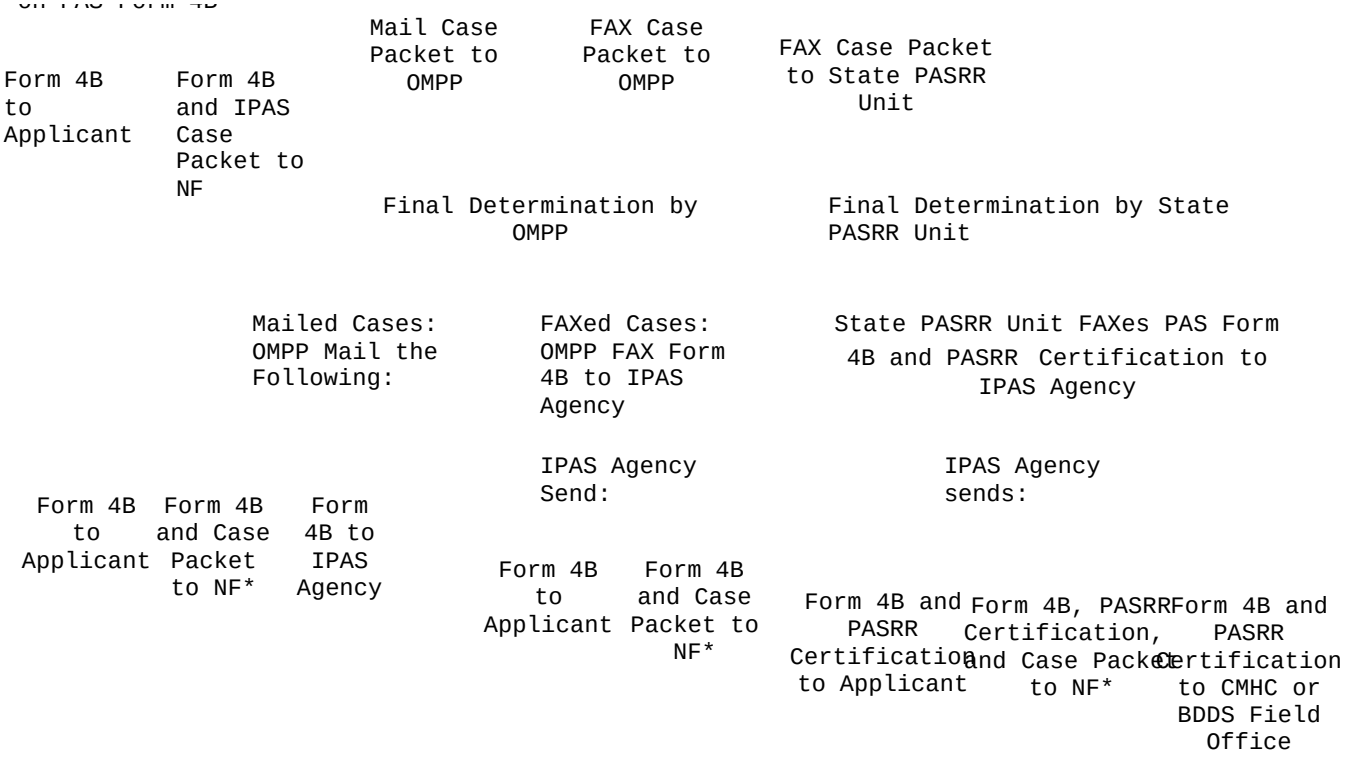
"Level II is not completed at this time although the above-named applicant's condition would ordinarily require PASRR Level II assessment. It is the responsibility of the NF to monitor the individual's condition. If the condition of behavior or mood either worsens, or has not improved, within the 90 days following NF admission, the NF will make a referral to the local CMHC for a non-routine ARR." (Caveat is also printed on the back of the Depression Screen form.)

5.3.3 Non-PASRR Private-Pay Cases

The local IPAS agency will issue the final determination for private-pay cases not covered by the categories above. The IPAS agency will use criteria of need for NF level of services which is consistent with that used by OMPP and the State PASRR Unit.

PROCESSING FOR FINAL DETERMINATION
Chapter 5





***NOTE:** When no NF has been designated by the applicant, the case packet with the PAS Form 4B and PASRR Certification will be retained by the IPAS agency until notification is received that a NF is chosen. The entire IPAS and/or PASRR case packet will then be forwarded to the designated NF for retention on the resident's chart.

A NF admitting an individual is responsible to contact the IPAS agency serving the area of the individual's home residence to obtain necessary approvals and documentation.

5.4 RECORDING THE IPAS FINAL DETERMINATION

Every valid IPAS Application form will receive a final determination. The IPAS/PASRR final determination is recorded on:

a) form PAS 4B for IPAS-Only; or
b) two (2) forms, form PAS 4B and the PASRR Certification, for PASRR. (For PASRR, both forms will be used together.)

The form PAS 4B may include specific limitations and/or recommendations. The PASRR Certification may contain specific service recommendations which will be addressed in the individual's Plan of Care by the NF.

5.5 DETERMINATION IN EFFECT FOR 90 DAYS

For an individual who has not entered the NF, the PAS approval for NF admission remains in effect for ninety (90) days, provided that the individual's condition or situation remains the same or has not improved to the extent that NF placement is no longer needed.

When the ninety (90) day PAS approval time limit has expired, but NF placement is still needed, the IPAS agency will:

a) update the case record; and
b) determine the reason that the individual was not admitted within the time limit; and
c) document this reason in the case record; and
d) resubmit the case for IPAS and/or PASRR approval PRIOR to NF admission.

All pertinent case records will be updated either by:

a) clearly marking the case with "Remains the Same;" or
b) supplementing it with new documents so marked and attached to the front of the old case record; and

c) initialing and dating the case record by the individual submitting the materials; and
d) including a cover letter explaining the circumstances and need for a new determination.

The updated case record will be processed as soon as possible. A new Form PAS 4B will be issued with a notation explaining the update.

5.6 FURTHER IPAS SCREENINGS PERMITTED

For individuals who have undergone the IPAS assessment and have been determined to be inappropriate for NF placement:

a) no further IPAS screenings may be requested by that individual for a minimum of one (1) year;
b) unless the medical condition or the support system of the individual is significantly changed to the degree that the attending physician certifies, in writing to the IPAS agency, that a new screening process is medically necessary.

The physician's certification will describe the specific nature of the pertinent change(s) and how it differs from the previous condition.

The IPAS agency will:

a) make the final decision on the need for another IPAS assessment based on the attending physician's certification; and
b) date-stamp the physician's certification with the date-received; and
c) enter it's certification of the need for a new IPAS assessment in the case.

The effective date of the IPAS Application for additional assessment will be the date of the physician's certification.

The IPAS agency will process the case by:

a) attaching the physician’s written certification and the IPAS agency’s certification to the top of the new IPAS case, with a copy of the previous IPAS case record attached;
b) clearly marking new documents to differentiate them from the old case documents; and
c) following all appropriate procedures for a new IPAS assessment and determination.

5.7 REFERRAL FOR CASE MANAGEMENT SERVICES

It is presumed that individuals who apply for NF placement may, if not admitted to the NF, be anticipated to be in a situation of possible jeopardy.

For all denied cases, the IPAS assessor or coordinator will:

a) make bona fide referral of the individual to available case management services; and
b) provide information on the assessment and necessary service needs identified through the IPAS assessment and care-planning to case management as part of the referral.

If no case management service is available or the individual does not meet eligibility criteria, the IPAS coordinator should assure that:

a) the applicant or his/her representative receives all service information which may have resulted from the IPAS assessment and care plan; and
b) provide enough detail so that the individual or interested representative will be able to pursue service acquisition.

5.8 DOCUMENTS: AVAILABILITY, CONFIDENTIALITY, DISPOSITION, AND RETENTION

5.8.1 Availability

Except as specified below, IPAS case documents may only be released with written authorization from the applicant or his or her legal representative.

IPAS case records are provided to the applicant, or his or her legal representative, upon written request. For purposes of individual care planning and service provision, Medicaid requires that the IPAS case record be provided to the NF to which the individual is admitted. Other state and federal programs, audits and surveys may have access to the IPAS case records as specified by law.

See Chapter 12.3.1 of this Manual for special PASRR Level II program provisions on availability of records to physicians, hospitals and individuals.

5.8.2 Confidentiality

Retention, access to, and distribution of IPAS case records will follow and maintain confidentiality in accordance with all pertinent state and federal laws and regulations.

5.8.3 Disposition

After IPAS final determination, the IPAS agency will distribute case records as follows:

a) the entire case record packet on which the IPAS determination is based is sent directly to the appropriate NF for retention on the NF active chart;
b) the entire case packet will be readily available to the state and federal auditors and surveyors; and
c) the form PAS 4B will be appropriately distributed with a copy sent to the CMHC or D&E Team by the IPAS agency when PASRR was required.

When there is a transfer between NFs, the entire case record will be transferred with a resident. (Also see Chapter 3.9.)

5.8.4 Retention

The IPAS agency will retain legible copies of all completed forms and related documents for a period of at least three (3) years from the last date of case action. The beginning date of the period of retention will be computed as follows:

a) for all Medicaid recipients, applicants or will-apply, denials, and marginal cases: the date of authorized OMPP signature on the PAS 4B;
b) for all PASRR related cases: the date of authorized State PASRR Program Unit signature on the PAS 4B;
c) for all IPAS-only, non-PASRR private-pay applicants, the date of signature on the PAS 4B form by the authorized IPAS agency.

If a reconsideration or appeal request is processed, the most recent decision date will be the beginning date of the retention period.

The IPAS agency will make case documents available to OMPP, the State PASRR Unit, the State Hearings and Appeals Section, and state or federal surveyors or auditors upon request and for audit purposes.

This page is intentionally blank.

IPAS & PASRR MANUAL

Table of Contents

THIS PAGE INTENTIONALLY LEFT BLANK.

Chapter 6

APPEALS; IPAS PENALTY; AND CLASS A INFRACTION

6.1 APPEALS, RECONSIDERATIONS, AND JUDICIAL REVIEW

An individual has the right to appeal and request a fair hearing when he/she disagrees with an adverse IPAS determination.

6.1.1 RECONSIDERATION

When there is additional documentation not previously submitted which is pertinent to the reason for denial, the individual may request a “reconsideration.” When appropriate, a reconsideration request can avoid the more lengthy, formal appeal process.

The reconsideration process is an informal process designed to provide a quick review of an adverse determination. Reconsideration is only appropriate when pertinent case documentation is available which was NOT submitted for the original determination.

6.1.1.1 Reconsideration Request

OMPP or the State PASRR Unit makes all IPAS or PASRR denial determinations. Reconsiderations will be:

a) requested through the IPAS agency which processed the IPAS case;
b) made as soon as the additional documentation is identified, but no later than within thirty (30) days of the effective date of the determination;
c) submitted by the individual, legal representative, NF, and/or attending physician acting on behalf of the individual.

Reconsideration does not replace the appeals process. An individual requesting a reconsideration will be advised to request an appeal at the same time.

a) If the reconsideration upholds the original adverse finding, the appeal will proceed.
b) If the reconsideration reverses the original adverse finding, OMPP or the State PASRR Unit will advise the Hearing and Appeals Section to cancel the appeal request.

6.1.1.2 Process

Upon receipt of a request for reconsideration and the new documentation, the IPAS agency will:

a) clearly mark each piece of new documentation as such;
b) add any appropriate comments and recommendations, clearly marked;
c) place the new documentation on top of a copy of the original case packet;
d) clearly mark the top of the entire case packet as a "Request for IPAS Determination Reconsideration;" and
e) resubmit it to OMPP or the State PASRR Unit, as appropriate.

The final determination on reconsideration requests rests with the OMPP or State PASRR Unit. Following review and determination, the appropriate reviewing entity will:

a) reissue the original PAS 4B determination form, keeping the original date of issue;
b) clearly mark it as a “ RECONSIDERATION DETERMINATION;” and
c) distribute the case packet with the new determination in the same manner as the original case packet.

6.1.2 APPEAL

An individual who disagrees with the final IPAS determination may appeal the decision. Brief instructions on the process to request an appeal are on the front of the PAS 4B final determination form with more detailed information on the back of the form or on an attached page.

6.1.2.1 Appeal Request

To request an appeal, the individual or representative will send a signed letter to the Hearings and Appeals Unit. (Address on PAS 4B form. Contact the IPAS agency for additional information or assistance.)

The letter needs to contain:

a) the individual's address and a telephone number where the individual can be reached; and

b) whenever possible, a copy of the final determination form attached to the letter, or a statement of the action being appealed. The individual's responsible party may assist in making the appeal request.

Hearings and Appeals will send a notice of the date, time, and place for the hearing to the individual, the IPAS agency, and OMPP or the State PASRR Unit. At or prior to the hearing, the individual:

a) will have the right to examine the entire contents of the case record at the IPAS agency;

b) may represent him/herself or authorize a representative such as an attorney, relative, friend, or other spokesman to do so;

c) will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, and question or refute any testimony or evidence presented.

6.1.2.2 Process

Hearings and Appeals will notify:

a) the appropriate IPAS agency when an appeal has been filed and a hearing has been scheduled on an IPAS case in its area; and

b) OMPP or the State PASRR Unit, as appropriate.

The IPAS agency will prepare two (2) sets of copies of the appellant's case file for submission to the hearing officer and the appellant (or his or her designated representative).

OMPP or the State PASRR Unit will prepare written testimony concerning the basis of its final determination.

This testimony will be provided to the local Medicaid caseworker or DFC designated representative to present at the hearing on behalf of the State. An IPAS agency may be authorized by OMPP or the State PASRR Unit to present information or testimony at a hearing. As an agent of the State for the IPAS and/or PASRR programs, the IPAS agency representative will support the State authority's finding.

An IPAS agency representative may attend a hearing at the request of an individual to represent him or her when the State IPAS or PASRR determination authority has overturned an IPAS agency recommendation of approval. The IPAS agency representative will make it clear that he or she is representing the individual, not the State authority, and that any information or testimony given is made in that capacity.

Following the hearing, the hearing officer will render a finding and written notification will be sent to the individual, the State entity, and other involved entities.

6.1.3 ADMINISTRATIVE REVIEW

If either party is in disagreement with the appeal decision, it can request administrative review by FSSA. The determination of the administrative law judge (ALJ) on the appeal is reviewed by the Secretary of FSSA (or an Agency designated representative) prior to submission to judicial review.

6.1.4 JUDICIAL REVIEW.

If either party disagrees with the decision after exhausting all administrative remedies, it may obtain judicial review. Information on how to obtain judicial review will be provided to the individual as part of the appeal determination notice.

6.2 IPAS PENALTY

Individuals incur a penalty if admitted to or remain in a NF after:

a) refusal to participate in the IPAS program; or

b) determination that NF placement is not appropriate.

NOTE: For PASRR, IPAS is a part of PAS/PASRR. It is a violation of the NF's Medicaid participation agreement to admit or retain persons requiring PASRR Level II assessment without IPAS and PASRR compliance, regardless of the IPAS penalty provision

6.2.1 Definition

The IPAS penalty consists of ineligibility for Medicaid reimbursement of NF per diem as a covered Medicaid service. It does not render the individual ineligible for Medicaid or other Medicaid covered services.

NOTE: Under Medicaid federal regulations, Medicaid reimbursement can be made only if the individual minimally meets the Medicaid criteria of need for NF services in effect at the time of admission or during the period for which reimbursement is requested, regardless of designee authorization. Appropriately applied designee authorization will only assure that the IPAS penalty is not applied for an individual who meets Medicaid eligibility requirements. It does not guarantee Medicaid reimbursement.

6.2.1.1 Failure to Notify Applicant

As soon as it is determined that the NF failed to provide notice of IPAS participation requirements, an individual:

a) must be notified of IPAS requirements; and
b) given the opportunity to complete the Application, choosing whether to participate in IPAS.

(If PASRR Level II is needed, the individual cannot refuse and be admitted to or remain in a Medicaid certified NF.)

NOTE: No time limit is specified in the governing IPAS law or rule for this notification requirement. 460 IAC 1-1-5(k) provides that an individual who was not notified of the requirement for IPAS and who is in a NF may be prescreened after receiving notification of the requirement.

An individual who was NOT notified of the IPAS program requirements by the NF and was admitted will incur no IPAS penalty unless, after receiving notification of the requirement, the individual:

a) Refuses to participate; or
b) Participates and is found not appropriate for NF placement, but remains in the NF. The IPAS agency will document the circumstances of an individual who was admitted to the NF without the appropriate IPAS notification, specifying applicable dates.

In this case, the IPAS penalty will be incurred beginning with the date of notification that IPAS is required rather than the date of NF admission.

The IPAS agency will clearly document the circumstances affecting imposition of the IPAS penalty in the case record and on the PAS 4A form and/or the PAS 4B form.

NOTE: Medicaid federal regulations, however, link reimbursement with the timely receipt of necessary documentation to determine eligibility. Substantial delay of such documentation may jeopardize Medicaid reimbursement for all or a portion of the time for which reimbursement is sought, regardless of other authorization(s). [42 CFR 456.260 and 261; 42 CFR 456.360 and 362]

A NF THAT FAILS TO APPROPRIATELY NOTIFY INDIVIDUALS OF IPAS REQUIREMENTS COMMITS A CLASS A INFRACTION. (See Chapter 6.3.)

- At the time it is determined that an individual was not notified, the IPAS notification will be provided. If the individual agrees to participate in IPAS, the assessment will be completed and a determination rendered as soon as possible, but no later than twenty-

five (25) days from application.

- If the individual refuses to participate, he or she will incur the penalty beginning with the date of notification that IPAS is required. The individual will incur no penalty for the period during which he or she was not notified.

6.2.1.2 Duration

The IPAS penalty lasts for up to one (1) year from the date of admission. In the IPAS law, the time is broken into two (2) levels which were linked to the Medicaid reimbursement system in effect at the time the law was written for:
a) intermediate care facility (ICF) (470 IAC 5-3-3);and
b) skilled nursing facility care (SNF) (470 IAC 5-3-2).

NOTE: An individual residing in the NF for more than one (1) year after incurring the penalty may request Medicaid reimbursement for NF per diem. However, the individual must still meet all Medicaid eligibility requirements.

"ICF:" IC 12-10-12-33 imposes a one (1) year period of ineligibility for Medicaid per diem reimbursement from the date of the individual's admission to the NF for an individual who:
a) Does not participate in IPAS; or
b) Participates in IPAS, is notified that placement in a NF is not appropriate, but enters or remains in the NF regardless of the IPAS finding.

"SNF:" IC 12-10-12-34 also imposes a period of ineligibility for Medicaid per diem for SNF care which differs from ICF in that it may be imposed for less than the full year.

The SNF penalty applies to an individual who:
a) refuses to participate in IPAS; or
b) participates in IPAS and is notified that the individual's placement is not appropriate.

For an individual in need of SNF care:
a) the penalty will continue only until the individual receives a determination that placement in SNF level of care is appropriate; but
b) in no case will it last more than one (1) year from the date of admission.

If the IPAS finding is that ICF care is the appropriate level, the provisions of the ICF penalty will continue to apply.

NOTE: OMPP has clarified that, since compliance with IPAS is required in Indiana for NF per diem coverage under Medicaid, Medicaid reimbursement for NF per diem will be withheld for an individual who would otherwise meet "SNF" need for NF services until the individual meets IPAS requirements.

6.2.1.3 Relief of the "SNF" Penalty Period

If an individual :
a) requires Medicaid NF per diem reimbursement before the expiration of the one (1) year penalty period; and
b) is in need of the level of NF services reimbursable under SNF;
the NF must contact the IPAS agency for directions as soon as possible. The IPAS agency will process an IPAS assessment, clearly noting the circumstances in the IPAS record.

The IPAS penalty:
a) will be lifted on the date that the individual receives an IPAS determination on PAS Form 4B that SNF placement is appropriate;
b) applicable time limits of the IPAS penalty period will be specified on the PAS Form 4B; and
c) the penalty period will be computed to include the period authorized under designee-authorization for temporary stay, except that the penalty will not be "imposed" for the designee-authorized time.

6.2.1.4 Other Provisions

a) A person admitted to a NF on appropriate designee authorization will not incur the penalty for the authorized period if, regardless of when the determination is made:
   1) placement in the NF is determined to be appropriate under IPAS; or
   2) the individual is discharged from the NF within fourteen (14) days after receipt of the decision that placement in the NF is inappropriate. This period of time allows for NF discharge planning.
b) The effective time of the penalty will be computed to include the designee authorized period plus the fourteen (14) days, but the penalty will not be imposed for the period under designee authorization or discharge planning.
c) The penalty will not be levied against an individual who is eligible for and requires Medicaid Waivered services, but chooses to go into a NF.
d) The incurred duration period of the penalty continues to be in effect even when an individual leaves the NF during the penalty period and is admitted again before the penalty period has expired.

NOTE: Even though an individual is still under a one-year penalty when he or she seeks readmission to a NF, the NF must follow all IPAS requirements anew. The NF:
a) will again notify the individual of IPAS requirements;
b) take a new Application; and
c) transmit it to the IPAS agency with a full explanation.
The IPAS agency will issue another PAS 4B explaining the status of the new IPAS application.

6.2.2 IPAS Agency Role

The IPAS agency will:

a) receive all Applications (including agreements and refusals to participate);
b) make appropriate judgments concerning their status;
c) record and track information;
d) process the Application; and
e) when an IPAS penalty has been incurred, issue notice of the penalty on PAS 4B.

6.2.2.1 Tracking Penalties

The IPAS agency is responsible:
a) for keeping a log of individuals who are under IPAS penalty;
b) in order to respond to requests from OMPP; and/or
c) to assure future assessments are not completed for individuals under IPAS penalty.

For individuals who are currently under IPAS penalty, the IPAS assessment will only be completed after:
a) the penalty has been discharged through an appeal;
b) it is determined that the penalty was incorrectly imposed; or
c) there is a claim that the individual needs "SNF" level of NF services.

6.2.2.2 PAS 4B Issuance

When it is determined that the IPAS penalty has been incurred, the local IPAS agency will issue a PAS 4B form which notifies the individual of the penalty and its consequences. For statewide consistency and accuracy, the following statement will be entered on the PAS 4B:

"Your Long-Term Care Services Application (IPAS Application) dated _____, which is checked that you do not agree to participate in Indiana's PreAdmission Screening (IPAS) program, has been received by this office. This notice is to advise you that admission to any Indiana licensed nursing facility without participation in IPAS carries a penalty of non-payment by Medicaid of per diem costs for up to one (1) year. The penalty period may be less if you require skilled nursing care. If you require skilled level of nursing care during this period and wish to

participate in IPAS, or if you have any questions concerning this notice, please contact (local IPAS agency information) immediately."

When the PAS 4B is issued by OMPP or the State PASRR Unit, substitute the following sentence for the first sentence:

"There has been an IPAS and/or PASRR determination that your placement in a NF is inappropriate."

Additional information or explanation may be added to the PAS 4B form.

6.2.2.3 Penalty Imposition

The IPAS penalty is incurred as specified in Chapter 6.2. It is imposed when an individual who has incurred the penalty applies for Medicaid NF per diem reimbursement during the penalty time period. OMPP will require a copy of the Form PAS 4B when the NF requests Medicaid per diem reimbursement to confirm the status of the individual.

NOTE: Every individual admitted to an Indiana licensed NF will have received a PAS 4 or, for Medicaid Waiver recipients, HCBS 4 issued either by the local IPAS agency, OMPP, or the State PASRR Unit.

6.2.3 Medicaid Reimbursement

After the expiration or termination the one (1) year penalty period, an individual may be eligible to receive Medicaid NF per diem reimbursement. The individual will need to meet all other Medicaid eligibility requirements.

NOTE: For instructions concerning an individual who was never notified of the IPAS requirement, see Chapter 6.2.

The NF will submit to OMPP:

a) a current Form 450B (Sections I-III, Physician's Certification of Need for Long-Term Care Services):
b) an explanation giving the specific NF admission date to show that the penalty period has expired;
c) a copy of the original PAS 4B indicating that the IPAS penalty applies;
d) if applicable for IPAS penalty relief due to SNF need, a copy of the PAS 4B which shows that the individual qualifies for relief from the IPAS penalty due to need for SNF level of care; and
e) any other documentation required by OMPP to document that the individual meets Medicaid requirements.

6.2.4 Waiver of the IPAS Penalty

Under specific conditions, an individual may request a waiver of the IPAS penalty so that he or she can be admitted to the NF before the IPAS determination is rendered.

a) Only an individual who is being assessed "From Home" may request the IPAS Penalty Waiver.
b) The Waiver of the IPAS penalty only applies if the IPAS assessment and determination are not completed within the twenty-five (25) day time limit.
c) If granted, the waiver of the IPAS penalty will only allow the individual to be admitted to the NF prior to the IPAS determination, without incurring the IPAS penalty for the period of time spent in the NF until the IPAS determination is rendered. (See Conditions for a Waiver, Chapter 6.2.4.1.)

Without the waiver of the IPAS penalty, admission to the NF before final IPAS approval may only be done under appropriate designee authorization. Admission without approval nullifies the "waiver" provision and incurs the IPAS penalty.

NOTE: Only the IPAS penalty is waived. All other requirements for NF admission and/or Medicaid reimbursement remain the same. IPAS assessment and determination will be completed as required, regardless of the waiver of the IPAS penalty.

The IPAS penalty Waiver does not apply to PASRR Level II cases.

6.2.4.1 Conditions for a Waiver

The IPAS agency will immediately investigate and document a request for a waiver of the penalty. When requested by the OMPP, the IPAS agency will provide sufficient information to ascertain whether conditions for the waiver request are met.

The following conditions will be investigated and documented by the local IPAS agency:

a) the applicant made an appropriate IPAS application;
b) the assessment was subject to the twenty-five (25) day "From Home" provision;
c) the applicant or his or her representative applied in writing in a timely manner for the waiver to the local IPAS agency;
d) the application for the waiver was made promptly following the expiration of the 25-day processing time period;
e) the NF, and hospital if applicable, cooperated in the IPAS assessment promptly;
f) the applicant, the applicant's physician, the applicant's custodian, and other necessary entities cooperated in the IPAS assessment in a timely manner; and
g) the IPAS determination was not rendered within the 25-day limit.

If all conditions above are met, the individual qualifies for the waiver of the IPAS penalty and will not be penalized for admission to the NF without IPAS prior approval or designee authorization.

6.2.4.2 Processing a Waiver Request

The request is made to the local IPAS agency. The IPAS agency will immediately compile the documentation for the request. The documentation of the criteria in Chapter 6.4.2.1 will be sent in a timely manner to the entity responsible for the final IPAS determination: OMPP or the IPAS agency.

As soon as the investigation is complete, the IPAS agency will immediately forward the request and the investigation results to OMPP, which will review all documentation and, either:

a) issue the IPAS case determination; or
b) if all conditions are met, issue a waiver of the IPAS penalty.

OMPP will::

a) render the decision within two (2) working days following receipt of the waiver request;
b) if given verbally, immediately issue the decision in writing;
c) maintain written documentation on the waiver decision for a period of not less than three (3) years; and
d) send a copy of the decision to the applicant or his or her representative, the NF, and the appropriate IPAS agency.

6.3 CLASS A INFRACTION

Indiana Code (IC 12-10-12) establishes specific functions to be performed by NFs under burden of committing a "Class A infraction." IC 34-4-32-4 establishes that a judgment of up to ten thousand dollars ($10,000) may be entered for a violation constituting a Class A infraction.

6.3.1 NF Notification Requirements

IC 12-10-12-6 specifies that a NF will provide notification of the IPAS requirements for NF admission to an individual or the individual's parent or guardian. IC 12-10-12-9 states that the "notification" required will be in writing on standardized forms prepared by DDARS and provided to NFs. The applicable forms are the "Long-Term Care Services Application" form and the IPAS Information Sheet.

The required notification (IPAS Information Sheet) will apprise the applicant that the:

a) applicant is required under State law to apply to the local IPAS agency for participation in Indiana's Pre-Admission Screening (IPAS) program;
b) applicant's failure to participate in IPAS could result in the applicant's ineligibility for Medicaid reimbursement for NF per diem in any NF for not more than one (1) year;
c) IPAS program consists of an assessment of the applicant's need for care in a NF made by

a team of individuals familiar with the needs of individuals seeking admission to a NF.

The notification will be signed prior to admission by the applicant or the applicant's designated representative, if the applicant is not competent.

If the applicant is admitted, the NF will:
a) retain one (1) signed copy of the notification for one (1) year; and
b) deliver the signed application to the local IPAS agency.

460 IAC 1-1-6(c) requires that the NF forward a copy to the IPAS agency within five (5) working days from the date of signature or, if the individual is admitted to the NF, from the date of admission. 460 IAC 1-1-6(d) makes the NF responsible for providing verification that:
a) the application for IPAS was made prior to admission;
b) an applicant admitted prior to final determination had designee authorization; and
c) the application and other designated documentation were forwarded to the IPAS agency within five (5) working days from the date of designee authorization.

Failure of an administrator, or the members designated to the governing body of the NF to ensure compliance with IPAS notice requirements, constitutes a Class A infraction.

Indiana Administrative Code, 460 IAC 1-1-6(d), clarifies that the NF is responsible for providing verification that:
a) the application for IPAS was made prior to admission;
b) an individual admitted prior to the IPAS determination had appropriate designee authorization for admission, as required; and
c) the copy of the application and other designated documentation were promptly forwarded to the IPAS agency.

6.3.2 Applicant Never Notified

IPAS rules specify that an individual who was not notified of the requirement for IPAS assessment and who is in a NF may be prescreened after receiving notification of the requirement. There is no time limit to this requirement. (See Chapter 6.2.1.1.)

6.3.3 Refusal to Sign Application

Also see Chapter 2.6.3.

The applicant or the applicant's designated representative may refuse to sign the IPAS Application after the NF gives notice. To document that notification was given, the NF's administrator or designee will clearly note the circumstances on the IPAS Application form, sign and date it. The applicant's name, address, and necessary identifying information need to be included on the IPAS Application form.

The NF will promptly send the unsigned, annotated IPAS Application form to the local IPAS agency in the same manner as if it had been signed. The IPAS agency will process it as a "refusal to participate." If the individual is admitted to the NF, a notation must be made on the PAS 4B regarding the IPAS penalty.

The IPAS agency must also make the certification of need for Level II at the bottom of the Level I. If the individual needs Level II, a Medicaid-certified NF will be in violation of its Medicaid certification agreement to admit the individual or allow him/her to remain.

NOTE: An IPAS Application will be submitted to the local IPAS agency for <u>every</u> individual admitted to a NF. This includes applications for "agree to participate," "refuse to participate," and "refuse to sign." The IPAS agency will issue a PAS 4B form for every Application form received.

6.3.4 IPAS Agency Report

460 IAC 1-1-7(14) requires the IPAS agency:
a) to report Class A Infractions to the prosecuting attorney serving the county of the NF (460 IAC 1-1-6);
b) regardless of the prosecuting attorney’s action on the report.

All such reports become a matter of public record and a copy of the report will become part of the case record.

6.3.4.1 Determination of Infraction

The IPAS agency will base the determination of a Class A infraction on requirements in 6.3.1, above.

6.3.4.2Progressive Action

Occasionally, circumstances beyond the NF's control may dictate a more moderate approach to the reporting requirement. The IPAS agency will judge whether the following progressive steps are appropriate to address the report of a Class A infraction for a particular NF.

NOTE: This procedure can not be used with NFs that have a demonstrated history of non-compliance with IPAS requirements. NFs which frequently ignore or refuse to comply with laws and regulations will be reported to OMPP for further action. A copy will also be sent to the County Prosecuting Attorney. (See Chapter 6.3.4.3 on Tracking.)

a) On the first violation, the IPAS agency may give the NF a verbal warning including a stipulation that the NF will secure training on the IPAS program requirements from the local IPAS agency. It is the responsibility of the NF to assure that training is provided to appropriate NF staff.

   The IPAS agency will document in its records that the verbal warning was given, including the reason for the use of the progressive reporting procedure.

b) The second violation requires a written warning from the IPAS agency to the NF administrator with courtesy copies to the owner/corporate level staff. The warning notice will document:
   1) the prior verbal warning;
   2) whether the required IPAS training was secured with details of the training; and
   3) a requirement for the NF to obtain additional IPAS training.

c) Further violations require a written report by the IPAS agency, on standardized forms, to the county prosecuting attorney. Specific reference to or copies of the warnings from the first two steps will be included or attached to report.

This progressive system will only be used when there is demonstrable evidence that the NF had a reasonable excuse for the non-compliance.

Whatever action is pursued, the IPAS agency will record in its files the nature of the action and the reason(s) for the selection of a particular approach for audit and accountability purposes. A copy of the correspondence will be placed in the individual’s case record.

6.3.4.3Report Format

To maintain consistency, all IPAS agencies will utilize the State designated format, on the agency's letterhead, to report the Class A infraction. This format has been reviewed and approved by the FSSA Office of General Counsel to assure that it meets IPAS requirements. (See Appendix Q.)

The report will specify the NF administrator, or the members designated to the NF governing body, as the individual held responsible for ensuring compliance with notice requirements. When applicable, the report will be carbon copied to the NF’s owners, corporate office, board, ISDOH, etc.

6.3.4.3 Documentation, Notification, and Tracking

In order to validate timely submission of the Application to the IPAS agency, the IPAS agency will stamp the date received on each Application form, Level I, and other pertinent documents.

Reports of Class A infractions will be documented in the individual’s case record.

The IPAS agency will also track the occurrence of Class A infractions by NFs, including the type of action taken by the IPAS agency.

If mail problems or other processing procedures are consistently being claimed as the reason Applications are missing or not received, the NF should make a follow-up phone call to the IPAS agency a few days after mailing to assure that the Application is received at the IPAS agency office.

A courtesy copy of the report of a "Class A infraction" will be sent to:

a) the NF administrator, the owner and/or corporate office, the designated NF governing body: and
b) the applicant or designated representative, as indicated.

Persistent problems of non-compliance will also be referred to the Indiana Department of Health, Division of Long-Term Care, the NF Ombudsman, and/or, if appropriate, APS.

Continuous and persistent Class A Infractions by a NF should be reported to OMPP and the State IPAS program.

COMPARISON OF CLASS A INFRACTION AND IPAS PENALTY
Chapter 6

Class A Infraction	IPAS Penalty
	And/Or
NF Fine: Up to $10,000	Resident: Ineligible for Medicaid Per Diem
Requires NF to: • Notify Applicant • Explain IPAS Program • Take Application • Keep Copy of Application on File for 1 Year • Send Application to IPAS Agency Immediately (or within 5 Days If Designee Authorized Admission)	Imposed if Applicant: • Refuses to Participate and Admitted • Agrees, Found Inappropriate, But Admitted -or- If Admitted with Authorization, Remains Beyond 14 Days • Notified after Admitted, Refuses -or- Agrees and Found Inappropriate, But Remains Beyond 14 Days·

NOTE: If Not Notified, Will Incur No Penalty Until Notified and Either: ¬ Refuses; or Remains after Finding of Not Appropriate. Penalty Begins with Date of Determination Notification.

“SNF”° Penalty: … “ICF” Penalty: … Ineligible for 1 Year … SNF Appropriate … Admission, But No Longer than 1 Year

IPAS Agency Notify County Prosecuting Attorney

(IC 12-10-12-33)
(IC 12-10-12-34)

§ *460 IAC 1-1-14(b): Allows 14 days for NF discharge planning for person temporarily admitted to NF under designee authorization who placement is determined to be inappropriate.*

§ *An individual not notified of the IPAS requirement will incur no penalty, unless the individual refuses to be screened after notification or is found to be inappropriate for NF services, in which case the individual will*

incur the penalty
beginning with the date of notification that IPAS is required. [460 IAC 1-1-14(d)]

§ *Refers to intermediate (I) care in a NF.*

§ *Admission: A person is admitted to a NF as soon as that individual is physically present in the NF, unless the admission*
is designee-approved. A person approved by a designee is considered admitted twenty-four (24) hours after entering
the NF. (460 IAC 1-1-2) The time of the IPAS penalty will be computed to include the period of authorization ,
but will not be imposed for such designee authorized time. [460 IAC 1-1—14(c)]

§ *Refers to skilled (S) care in a NF.*

§ *IC 12-10-12-34 allows an individual needing the level of NF services previously designated SNF, who refused IPAS*
at NF admission, to decide to agree and be IPAS assessed. If skilled NF placement is determined to be appropriate,
the remainder of the IPAS penalty will be lifted effective when the individual receives the determination on the
PAS 4B form. In no case will the IPAS penalty last more than one (1) year from the date of NF admission. [460 IAC 1-1-14(c)]

This page intentionally left blank.

IPAS & PASRR MANUAL

Table of Contents

THIS PAGE INTENTIONALLY LEFT BLANK.

Chapter 7

MEDICAID WAIVER AND CASE MANAGEMENT

7.1 MEDICAID WAIVER SERVICES

The Medicaid Waiver Services program applies to IPAS in that:

a) applicants for Indiana's "Aged and Disabled" (A&D) and "Medically Fragile Children" (MFC) Waivers must participate in Indiana's IPAS program; and

b) eligibility for Medicaid Waiver services should be considered by the IPAS assessor when constructing the IPAS and/or PASRR plan of care.

Medicaid Waiver Services are those specific in-home and community-based services available for Medicaid reimbursement only under a federally approved "waiver." The parameters of each Medicaid Waiver service are contingent on the limits requested by each state and approved by HCFA. IPAS requirements must be met by individuals covered under these two (2) Waivers.

7.1.1 General Information

The A&D and MFC Waivers provide services to aged adults and persons with disabilities who would otherwise require the level of services provided in a NF.

7.1.1.1 Eligibility

In general, Medicaid A&D and MFC Waiver eligibility requirements direct that the individual must be:

(a) eligible for Medicaid;
(b) at risk of institutionalization (in the absence of Medicaid Waiver services);
(c) screened under IPAS;
(d) meet need for NF level of services criteria (Level of Care); and
(e) be given the choice to utilize the Medicaid Waiver services or be admitted to a NF.

The criterion of "at risk of institutionalization" means that:

a) the individual must, but for the availability of Medicaid Waiver service(s), meet all requirements of need for NF level of services; and
b) if qualified, must be given a choice to accept the Medicaid Waiver service(s); or
c) be admitted to a NF.

All requirements for NF placement must be met and approval for NF admission rendered PRIOR to the offer of Medicaid Waiver services.

Each Medicaid Waiver, depending on the type of Waiver being considered, may impose other restrictions.

7.1.1.2 PASRR Requirements

As soon as a recipient of A&D or MFC Medicaid Waiver services chooses placement in a NF, the IPAS Agency will:

a) determine whether PASRR Level II assessment is required; and
b) if Level II is needed, make referrals for Level II directly to the CMHC or D&E Team;
c) send the letter of Level II referral to the applicant and/or health representative, Waiver Services case manager, and NF; and
d) regardless of need for Level II, send a copy of the IPAS agency certified Level I to the NF.

See Chapter 15 for instructions for processing Level II assessments for Medicaid Waiver recipients.

7.1.2 NF Admission of a Medicaid Waiver Services Recipient

The "freedom of choice" to enter a NF is applicable:

a) throughout the time that an individual meets the Waiver requirements; and
b) is an active recipient of the A&D and MFC Waivers.

7.1.2.1 NF Action

When a NF receives a request for admission from a Medicaid Waiver recipient, the NF must:

a) immediately notify the IPAS agency and/or the Waiver Case Manager of the request;
b) PRIOR to admission or immediately following designee approved admission.

As always, the NF must NOT admit or retain any individual:
a) for whom it cannot provide the level of services needed; or
b) who requires PASRR Level II, but has not been assessed and approved for placement.

A NF must assure that, for every individual it admits, it has a copy on the chart of the:
a) PAS Form 4B; or
b) for Medicaid Waiver recipients, the HCBS Form 3: Statement for Freedom of Choice (Appendix S) or the HCBS Form 7: Transmittal for Medicaid Level of Care Eligibility (Appendix R).

7.1.2.2 Medicaid Waiver Recipient/Care Manager Action

A Medicaid Waiver recipient must:
a) report any change in circumstances which affects eligibility for Waiver services; and
b) choosing NF placement is a reportable change.
The individual or the individual's legal representative must immediately contact the Medicaid Waiver care manager.

It is the responsibility of the Medicaid Case Manager to:
a) assure that the recipient understands the need to report such changes PRIOR to NF admission, whenever possible or immediately following NF admission; and
b) report or assure that the selection of NF admission is reported to the appropriate IPAS agency for a determination of need for Level II assessment.

7.1.2.3 Transmittal of Case Record to NF

Each NF is required to:
a) maintain certain case documentation on file; and
b) utilize the assessment and needs findings in its care planning.
The Waiver Care Manager must provide the NF with the necessary IPAS/PASRR documentation and case record at the time of admission.

Applicable documentation which the Waiver Case Manager must provide and which the NF must maintain on the NF active record and use for the Care Plan corresponds to the IPAS case packet. It includes, at a minimum, the following forms:
a) Application for Long-Term Care Services;
b) PASRR Level I;
c) Form 450B, Sections I-III, Physician Certification of Need for Long-Term Care Services;
d) (For MR/DD, include Form 450B, Section VI);
e) PASRR Level II Assessment, when applicable;
f) Long-Term Care Services Eligibility Screen;
g) Form HCBS 3, Waiver Freedom of Choice, showing choice of NF or HCBS Form 7, Transmittal for Medicaid Level of Care Eligibility.

7.1.3 NF Request for Medicaid Reimbursement

A NF submits its request for Medicaid reimbursement of NF per diem to OMPP following the usual procedures.

There will not be a PAS Form 4B for an individual who, immediately prior to NF admission, was a Waiver Services recipient. Either the Form HCBS 3 or HCBS 7 will replace the PAS 4B when the NF requests reimbursement for NF per diem from OMPP.

To assure that OMPP can expeditiously process the request for NF per diem approval, documentation submitted to OMPP needs:
a) to be clearly marked by the NF as "Medicaid Waiver Services;"
b) in the top margin of the Form 450B;
to alert OMPP to the status of the request.

Request for Medicaid Waiver Services at IPAS Agency

IPAS / Medicaid Waiver Assessment and Determination

Approved - May Choose:

To Remain in Community and Receive Medicaid Waiver Services

Admission to a NF

Disapproved

Remain in Community

May Appeal

NF Admission without IPAS Approval Incurs IPAS Penalty

(See Chapter 15 for PASRR and the Medicaid Waiver)

When PASRR Level II Is Needed, Admission to a Medicaid-Certified NF Requires That:

À Level II Must be Completed PRIOR to NF Admission (Unless Qualifies Under PASRR Temporary Admission Criteria); and

Á The PASRR Level II Determination has been Issued on the PASRR Certification Form (MI State Form 47176 listed at bottom of page or MR/DD SF 46922) No PAS 4B: Use HCBS Form

7.2 CASE MANAGEMENT REFERRAL

For all denied cases, the IPAS assessor or coordinator must:

a) make a bona fide referral of the individual to available case management service(s);

b) provide information on the assessment and necessary service needs identified through the IPAS assessment and care-planning.

This information will avoid duplication of effort and expedite processing by the case management system receiving the referral.

When no case management service is available or the individual does not meet requirements, the IPAS coordinator should assure that the applicant or his/her representative receives all service information which may have resulted from the IPAS assessment and care plan. This information should be detailed enough that the individual or interested representative will be able to pursue identified services or options.

IPAS & PASRR MANUAL

Chapters 8 and 9 reserved for future use.

THIS PAGE INTENTIONALLY LEFT BLANK.

CHAPTER 10
INTRODUCTION TO PASRR

THIS PAGE IS INTENTIONALLY BLANK.

Chapter 10
INTRODUCTION TO PASRR

10.1 PROGRAM BASIS AND PURPOSE

Nursing facility (NF) PreAdmission Screening/Resident Review (PASRR) is federally mandated under the Omnibus Budget Reconciliation Act of l987, Public Law 100-203 (OBRA '87), and Public Law 101-508 (OBRA '90). [42 U.S.C. Sections 1306r(b)(3)(F) and 1306r(e)(F)] Effective January l, l989, PASRR is required for all individuals with MI and/or MR/DD who apply to be admitted to a Medicaid-certified NF.

Section l9l9(b)(3)(F) of the Social Security Act prohibits a Medicaid certified NF from:

a) admitting or retaining any individual who has mental illness (MI) and/or mental retardation or a related condition (MR/DD), unless:
b) the State PASRR program has determined:
   1) that the individual, because of his or her physical and mental condition requires the level of services provided by a NF; and
   2) if the individual needs a NF level of services, whether the individual needs specialized services (SS) for the MI and/or MR/DD condition; or
   3) if the individual needs NF level of care but does not require specialized services, the services of less intensity than specialized services (SS) which the individual will need if admitted to a NF.

For residents who have a condition of MI and/or MR/DD, PASRR reviews and determinations must be repeated when there is a significant change in condition.

10.2 TWO-PART PROGRAM: PAS/PASRR AND RR/PASRR

The PASRR program can be divided into two parts:

a) PreAdmission Screening (PAS); and
b) Resident Review (RR).

The basic requirement for Level II assessment is the same for both parts, but the procedures differ.

10.2.l PAS/PASRR

PreAdmission Screening (PAS) refers to the assessment and determination required PRIOR to NF admission or, if approved for a temporary admission, completed within specific time frames following admission.

To meet this requirement and avoid duplication, Indiana incorporates Indiana's PreAdmission Screening (IPAS) program into the PASRR process through its Medicaid State Plan. (See Chapters 1 through 9 for IPAS procedures.) Thus, IPAS provides the following functions for the PAS portion of the PASRR:

a) identification of persons seeking admission to Medicaid certified NFs;
b) review of and certification of need for Level II Assessment;
c) written notice to the individual of referral for Level II;
d) activating mechanism to the CMHC or D&E Team to complete a Level II Assessment;
e) provision of necessary data to evaluate and determine need for NF level of care including physical status, functional assessment (activities of daily living), alternative services and/or placement;
f) liaison between NF, family, physician, and other entities as necessary;
g) review of documentation and recommendation for placement; and
h) coordinating entity to compile case documents for submission to the State.

In addition, the federal Medicaid Manual Transmittal Number 42, issued in May, l989 required states to interface the PASRR process with other existing or future NF preadmission screening and resident assessment procedures to the greatest extent possible.

In summary, the IPAS Agency must certify whether there is a need for Level II assessment, make referrals for Level II assessments, assure that documentation submitted to support PAS/PASRR findings is complete and accurate, including necessary signatures, credentials, and dates entered. Each IPAS/PASRR case must be reviewed by the PAS Agency prior to submission for completeness and consistency.

10.2.2 RR/PASRR

Resident Review (RR) is an evaluation which parallels the PAS process for a NF resident who has completed PAS requirements. (See Chapter 14.) RR Level II is required:

a) following a substantial change in the MI and/or MR/DD condition of any resident; or
b) yearly for certain residents determined to be MI and/or MR/DD and in need of services.

(NOTE: For PASRR purposes, change in condition means a change in the MI and/or MR/DD condition, but does not include changes of the medical condition only.)

An initial RR/PASRR review of all NF residents with MI and/or MR/DD conditions who entered Medicaid-certified NFs prior to January l, l989 was required to be completed no later than April l, l990. From April l, l990 to June 30, 1997, an annual RR Level II was required for all NF residents with MI and/or MR/DD conditions. Effective July 1, 1997, some NF residents:

a) who had a prior Level II; and
b) were determined to have MI and/or MR/DD conditions; but
c) are not in need of continued mental health services;

are exempted from the annual RR requirement. At the time that they have a significant in MI and/or MR/DD condition, they will need to have a new Level II.

NOTE: NF discharge to a community-based or other institutional setting requires that the IPAS and/or PASRR assessment process is completed again for NF admission.

INTERRELATIONSHIP OF IPAS AND PASRR (Chapter 10)

	IPAS	PASRR	
	IPAS	**PAS of PASRR**	**RR of PASRR**
	1. All Indiana Licensed NFs 2. All Applicants and Residents, Regardless of Payment Source	1. All Medicaid-Certified NFs 2. All Applicants and Residents, Regardless of Payment Source	
	IPAS and PAS of PASRR Admission and Assessment Process		RR of PASRR Assessment Process

10.3 PASRR PARTICIPATION REQUIREMENTS

In general, PASRR requires:

- all Medicaid-certified NFs to participate;
- all individuals admitted to or residing in a Medicaid-certified NF to participate; and
- participation in IPAS for all new admissions who also need a Level II assessment.

10.3.1 All Medicaid-Certified NFs

ALL facilities that are Medicaid-certified to provide Medicaid reimbursable NF services are required to participate in the PASRR program, regardless of whether any residents are currently eligible for Medicaid. Every Medicaid-certified NF MUST comply with federal PASRR admission requirements, regardless of an individual's intended length of stay or source of

payment: Medicare, VA contract, private-pay, insurance Medicaid, or other.

NOTE: Compliance with PASRR requirements is a contract issue of a NF's Medicaid participation agreement. To refuse to comply or ignore requirements is to jeopardize a NF's Medicaid-certification status.

This requirement also extends to:
a) Medicaid-certified hospital-based Extended Care Facilities (ECFs), Transitional Care Units (TCUs), subacute rehabilitation units; and
b) any facility or unit holding Medicaid-certification as a nursing facility, regardless of IPAS exemption.
(Also see Chapters 2.10, 3.7, and Appendix D.)

NF Participation in IPAS and PASRR (Chapter 10)

IPAS Applies to:
Indiana Licensed NFs under IC 16-28
(Including Comprehensive Care Only, Medicare, and/or Medicaid certification)

PASRR Also Applies to:
Medicaid Certified NFs

10.3.2 All Applicants and Residents

PASRR applies to ALL individuals:
a) who seek admission to or continued placement in a Medicaid-certified NF;
b) regardless of income or resources [including those whose care will be reimbursed by Medicaid, Medicare, VA contract, insurance or any other source(s), including private-pay].
For PAS, they are required to complete a PASRR Level I, Identification Screen, and, if indicated, the PASRR Level II assessment. See Chapter 13. (For RR, see Chapter 14.)

Temporary admission requirements differ between the IPAS-Only and PAS/PASRR program requirements. See Chapter 3 for IPAS-Only details.

10.3.3 Cooperation with Level II

Timely and expeditious PASRR assessments and determinations rely on the cooperation of:
a) the individual, his or her family, guardian, and/or health care representative;
b) the physician;
c) the NF;
d) the hospital, when applicable; and
e) any other pertinent entity involved with the PASRR process;
to provide necessary information and documentation.

The NF must have available:
a) the charts of ALL NF residents identified as having, or suspected of having, a condition of MI and/or MR/DD;
b) for review by the IPAS assessors, the Medicaid NF Audit Team auditors, the CMHC (for MI) or the D&E Team (for MR/DD or MR/DD/MI), the State PASRR Unit, OMPP, other federal and state auditors, and other legitimate entities.

The IPAS agency, CMHC, and/or D&E Team assessors are authorized to:
a) visit with those individuals who require Level II assessments;
b) examine necessary records and charts;
c) interview direct care providers; and
d) complete any necessary testing.

Medicaid providers agree to abide by all applicable federal and state laws and regulations when they execute a provider agreement with the Indiana Medicaid program. Lack of cooperation with the PASRR assessment requirements and process:
a) is a Medicaid certification matter; and
b) can result in the withholding of payment for services.

10.3.4 PASRR Must Participate in IPAS

NF applicants to a Medicaid-certified NF who trigger a PASRR Level II assessment MUST participate in Indiana's IPAS program. When PASRR is required, IPAS becomes an integral component of the PASRR assessment as explained in Chapters 1.3 and 10.3. Therefore, an applicant who requires Level II assessment CANNOT REFUSE to participate in IPAS and be admitted under IPAS penalty or continue to reside in any Medicaid-certified NF.

10.3.5 Resident of State Psychiatric Hospital

Regardless of known diagnosis, any individual who:
a) is a current resident of a state psychiatric hospital (not discharged from the institution); or
b) is a recently discharged (within the past two years) resident:
must be assessed with a Level II and a determination made PRIOR to NF admission.

This applies to Indiana state psychiatric hospitals as well as those in other states.

NOTE: Do not apply:
a) the dementia exclusion;
b) or temporary placement provisions:
   1) for PASRR Exempted Hospital Discharge; or
   2) PASRR Categorical Determinations for Respite and APS:
   for residents of state facilities or group homes.

Under the gatekeeper responsibilities of each Indiana CMHC, the gatekeeper CMHC has primary responsibility for completion of the Level II for residents of an Indiana state psychiatric hospital.

When the state hospital is planning to seek NF placement for a patient:
a) the state psychiatric hospital will notify its gatekeeper CMHC;
b) the gatekeeper CMHC will work with the hospital to review the patient’s potential for placement and to notify the local IPAS agency;
c) the IPAS agency local to the state psychiatric hospital will conduct the IPAS assessment; and
d) the gatekeeper CMHC will conduct the PAS/PASRR Level II.

When a gatekeeper CMHC is located at some distance from the state psychiatric hospital in which the individual currently resides, the gatekeeper CMHC has the option to defer assessment to the CMHC serving the locality of the state psychiatric hospital. This may occur because geographic distance makes completion of a Level II impractical and/or cost prohibitive.

10.3.6 Nonresident Applicants

PASRR requirements apply to all nonresident applicants who trigger the PASRR Level II, using guidelines specified in Chapter 3.8 of this Manual. Requests for temporary NF admission will follow Chapter 3.8.3.

- PASRR/MI "Dementia Exclusion" (Chapter 13.4); and
- PASRR "Exempted Hospital Discharge" exclusion (Chapter 13.5):

will only be applied AFTER the full IPAS assessment and determination approving NF admission

are complete.

PASRR will accept Level II assessments completed by another state:
a) on the other state’s form, as long as federal requirements are met; or
b) on Indiana's PASRR Level II assessment form.
Upon request, the IPAS agency will provide Indiana’s form to the other state, explaining Indiana’s requirements.

NOTE: PASRR Level I screens and Level II assessments from other states must meet Indiana's minimal PASRR requirements to be accepted in lieu of Indiana's format. The NF and the IPAS agency should:
a) thoroughly review any out-of-state documents prior to acceptance; and
b) when there is a discrepancy with Indiana's requirements which the IPAS agency cannot resolve, consult the PASRR staff at the State PASRR Unit prior to any action.

To avoid duplication, the IPAS agency should:
a) question each out-of-state applicant concerning possible contacts with other NFs; and
b) if located in the catchment area of another IPAS agency, coordinate application and assessment processing.
Information should be exchanged to assure consistency of documentation.

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 11
LEVEL II ASSESSMENT

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 11
LEVEL II: ASSESSMENT

11.1 ASSESSMENT

The Level II assessment is a comprehensive evaluation to determine:

a) whether NF applicants and residents who have (or are suspected of having) a condition of MI and/or MR/DD meet the criteria for PASRR MI and/or MR/DD; and
b) whether NF level of services are needed;
c) whether MI and/or MR/DD specialized services are needed; and
d) if there is an MI and/or MR/DD condition, whether services of less intensity than specialized services are needed and what those services are.

The PASRR Level II assessment is actually composed of two (2) parts:

a) PASRR/NF is the assessment of the need for the level of medical services provided in a NF (NF Level of Services need) documented by the IPAS agency for IPAS or the NF for RR; and
b) PASRR/MI or PASRR/MR/DD or PASRR/MI/MR/DD is the assessment for a condition of MI and/or MR/DD and the need for specialized services. This part of the Level II assessment is completed by the CMHC or hospital for MI individuals, and by the D&E Team for persons with MR/DD or MI/MR/DD.

- NOTE: Both parts must be done for a Level II to be complete.

The PASRR Level II assessment and determination should provide the following results/findings:

a) "Needs/Does Not Need" NF level of services (NF LOS);
b) "Is/Is Not" MI, MR/DD or MI/MR/DD;
c) "Needs/Does Not Need" specialized services (SS);
d) if no SS are needed: “Needs/Does Not Need” services of lesser intensity than SS if admitted to a NF.

11.2 ASSESSMENT COMPONENTS

COMPONENTS OF THE LEVEL II
Chapter 13

PASRR Level II Assessment

I. PASRR/NF:	II. PASRR/MI or PASRR/MR/DD or PASRR/MI/MR/DD:
Need for NF Level of Services [Usually referred to as “NF Level of Care (LOC)”]	Assessment of MI and/or MR/DD Condition [Usually called “Level II”]

11.2.1 PASRR/NF (Need for NF Level of Services)

The first part of the Level II assessment is the documentation of need for NF level of

services. Based on the submitted documentation, the State MI or MR/DD authority (as appropriate) is required when making their determinations:

a) to determine for each applicant or resident with MI and/or MR/DD whether, due to his or her physical and mental condition, he or she requires the level of services provided by a NF; and

b) to use criteria relating to the need for NF care that is consistent with Medicaid criteria, or any supplementary criteria adopted by the State Medicaid Agency under its approved State Plan.

- For PAS - PASRR/MI Cases Only: At any point that it is determined that the individual does not meet the need for NF services criteria, the IPAS agency:
  a) may stop the Level II assessment or the Level II assessment process itself; and
  b) will confer with the State PASRR Unit to confirm the decision; and
  c) if the State PASRR Unit concurs that there is no need for NF services, will:
     1) not make a referral for a PASRR/MI Level II; or
     2) notify the CMHC that the Level II does not need to be completed; and
  d) clearly document the reason the PASRR/MI Level II was not triggered or completed in the case record;
  e) obtain a completed Inappropriate Referral form from the CMHC; and
  f) submit the case to the State PASRR/MI Unit for the final case determination (because Level II would have been required, although it was not done).

This provision does NOT apply to MR/DD or RR cases. Under MR/DD and RR, required assessments and determinations (both the NF need documentation and the Level II assessment, if required) must be completed.

If a determination to deny is overturned on appeal or reconsideration, the PASRR/MI or PASRR/MR/DD portion of the Level II assessment must be completed PRIOR to issuance of the corrected determination with the appeal or reconsideration finding.

- NOTE: If a finding of no PASRR/NF need is overturned by either reconsideration or appeal, the PASRR/MI Level II Mental Health Assessment must be completed prior to issuance of a final determination by the State mental health authority.

11.2.1.1 Criteria

The evaluator must assess:

a) whether the individual's total needs are such that they can be met in an appropriate community setting; or

b) whether the individual's total needs are such that they can be met only on an inpatient basis (including placement in a home and community-based services waiver which would offset the need for inpatient services); or

c) if inpatient care is appropriate and desired, whether the NF is an appropriate institutional setting; or

d) if inpatient care is appropriate and desired, whether the NF is inappropriate and another setting such as an ICF/MR, IMD, or psychiatric hospital is appropriate. (Also see Chapter 13.5.)

11.2.1.2 Data

Data considered must be current and relevant to the individual's condition. Data to document the determination must be in written form. Need for NF services data must include at a minimum:

a) evaluation of physical status (e.g., diagnosis, date of onset, medications, medical history, prognosis, etc.);

b) evaluation of mental status (e.g., diagnosis, date of onset, history, likelihood that individual may be a danger to himself/herself or others, suicidal ideation, etc.); and

c) evaluation of functional impairment (activities of daily living, degree of impairment, offsets of the need for care, etc.).

11.2.1.3 Documentation and Process

The following documentation is required for the determination of need for NF services (PASRR/NF).

- PAS: Medical

For PAS, the IPAS agency is responsible to collect available medical information for the determination of need for NF level of services. (The CMHC or D&E Team will provide the other part of the PASRR Level II, namely the PASRR/MI or PASRR/MI/MR/DD assessment, for the IPAS agency to include with the case record. See Chapters 4, 13.3, and 13.4.)

The primary source of medical documentation is:

a) the Form 450B - Sections I-III, Physician Certification of Need for Long-Term Care Services [see Appendix M]; and/or
b) when available following temporary NF admission, the MDS (Minimum Data Set) of the NF's Resident Assessment; and
c) when PASRR/DD, Form 450B - Section VI (see Appendix II); and
d) for out-of-state NF residents, 30 days of nursing notes; and
e) any additional pertinent medical documents submitted to support need for NF level of services.

- NOTE: Lack of adequate and incomplete medical documentation supporting need for NF level of services is the primary reason for most denials of NF placement.

For both PAS and RR: PRIOR to submission of the case record for determination, the entity submitting the Form 450B must:

a) check the Assessment Type at the top of the document and/or enter a notation of the reason the Form 450B is being submitted;
b) assure that all applicable information is entered in "Section I-Recipient Identification;"
c) check that the name and address of the NF is entered for the NF to which the individual is being admitted or in which he or she is a resident;
d) review "Section II-Physician's Medical Evaluation" for completeness;
e) assure that the physician has certified the level of care, signed and dated the form; and
f) review and assure that any additional documentation submitted is complete.

- RR: Medical

RR cases may use the same documentation as PAS or submit other/additional medical documentation and records to determine the need for NF level of services (also see Chapter 14.):

a) Yearly RR (YRR) (Chapter 14.4) requires proof of a prior determination of need for NF services documented on:
   1) a PAS Form 4B; or
   2) a state-certified Form 450B, Physician Certification; or
   3) if NF need was first determined as a result of a prior Significant-Change Level II, for a resident under IPAS penalty, the PASRR certification form; or
   4) if need for NF level of services has never been determined, but a Level II should have been completed in the past, follow procedures for either Significant-Change RR or Missed Significant-Change RR. (See below and Chapter s 14.2 or 14.3.)
b) Significant-Change RR (Chapter 14.2) requires:
   1) same documents as YRR numbers 1 - 3, above; and also
   2) current medical information, which may include:
      i) a current MDS; and/or
      ii) a new Form 450B, Sections I-III; and/or
      iii) additional medical information attached to the prior certified Form 450B; and/or
      iv) nurses notes; and/or
      v) other documents.

- NOTE: For RR it is the NF's responsibility to provide sufficient documentation for the State PASRR Unit:
  a) to verify that need for NF level of services was previously made (YRR, Missed PAS, or Missed YRR); or

b) for residents admitted under IPAS penalty who did not require PASRR, to make a determination of need for NF level of services (Significant-Change RR or Missed Significant-Change RR).

- NOTE: The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF to show medical need for NF level of services.

a) Documentation submitted by the NF to the CMHC or D&E Team should be included with the Level II case sent to the state authority for determination.

b) When insufficient, the State PASRR Unit will get additional documentation directly from the NF. (See Chapter 14 for RR.)
c) When medical documentation is missing from the case record, the case will not be processed and will be returned to the CMHC or D&E Team for missing documentation.

11.2.2 PASRR/MI

The second part of the Level II process is the PASRR/MI evaluation for individuals with a condition of MI, commonly called the “Level II.” The results of MI Level II mental health assessments are to be recorded on forms prescribed by the State PASRR Unit which:
a) are self-contained, because directions necessary for completion are contained on the form itself; and
b) are developed to elicit specific documentation required by federal law for the PASRR/MI determination.
Additional documentation pertinent to the case may be also appended.

11.2.2.1 Assessment of Mental Health

The PASRR/MI Level II mental health assessment must:
a) be an independent physical and mental evaluation;
b) performed by an entity other than the State mental health authority (see Chapter 11.3.1.2);
c) which reviews, at a minimum, the areas stipulated on the designated Level II: PASRR/MI Mental Health Assessment form (See Appendix Z.); and
d) provides findings which are adequately summarized, recorded, and appropriately certified on the PASRR/MI Level II form.

The PASRR/MI assessor must make an independent finding of whether the individual;
a) has a condition which meets the PASRR/MI definition of mental illness (MI) (See Chapter 13.2.1.1 and Appendix C.); and
b) needs specialized mental health services (See Chapter 13.5.1.); or
c) if specialized services are not required, needs mental health services of lesser intensity than specialized services while residing in a NF (See Chapter 13.5.2); and
d) if so, identify the mental health services to be provided in the NF.

The PASRR/MI Level II assessment must:
a) result in a determination of the AXIS I, II and III diagnoses, independent of those diagnoses recorded on the chart or other medical records; and
b) document and support these findings on the Level II form itself.

- NOTE: When more than one (1) Axis I diagnoses is determined, they must be ranked in order of predominance with the principal/primary condition listed first.

11.2.2.2 Definition of Mental Illness

See Appendix C for the full definition of mental illness (MI).

In brief, an individual is considered to have a condition of mental illness if he or she:
a) has a current primary or secondary diagnosis of a major mental illness (as defined in

DSM-IV or the current Diagnostic and Statistical Manual) limited to the following: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability; and

b) does not have a concurrent PRIMARY (PRINCIPAL) diagnosis of documentable dementia (including Alzheimer's Disease or related disorder).

- NOTE: For purposes of the PASRR program, a diagnosis of alcoholism (ETOH) without any indicator of a major mental illness as defined above will not require a PASRR/MI Level II. Behavioral problems due to alcoholism or dementia do not trigger a Level II, but should be clearly identified to a NF which is considering admission so the NF can determine whether it can meet the individual's needs.

The exception to this criteria is an individual who is an inpatient in a state psychiatric hospital. (See Chapter 10.3.5.)

An IPAS agency should:

a) always thoroughly question and explore requests for admission from inpatient psychiatric units;

b) to determine and assure, as much as possible, that there is not a co-existing diagnosis of major mental illness (or for dementia patients, a diagnosis of serious MI which is primary to the dementia);

c) before certifying on the bottom of the Level I that Level II is not needed.

11.2.2.3 Designated MI Assessors

Public Law 101-508, Section 4801(b)(1-8), referred to as OBRA ’90, restricts entities that may conduct PASRR assessments and determinations. Under U.S.C. 1396r, Section 1919 (b)(3)(F)(iii) states: “A state mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this paragraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).”

42 CFR 483.106(e)(3) further clarifies this provision: “The evaluation of individuals with MI cannot be delegated by the State mental health authority because it does not have responsibility for this function. A person or entity other than the State mental health authority must perform the evaluation function. In designating an independent person or entity to perform MI evaluations, the Sate must not use a NF or an entity that has a direct or indirect affiliation or relationship with a NF.”

Interpretative guidelines published in the Federal Register dated November 30, 1992 provides the following clarifications and instructions:

“Individual physicians or mental health professionals (unless they are owners, operators, or employees of the NF) would not be precluded from performing those portions of the PASRR evaluations which they are qualified to perform….local boards which own or operate public nursing facilities (NFs) are barred from PASRR evaluations.”

Each entity completing a PASRR/MI Level II assessment must review and assess its activities in this regard to assure that this requirement is met.

- NOTE: This requirement does not apply to completion of the PASRR Level I: Identification Screen. As indicated on the Level I form, the physician, hospital discharge planner, NF, case manager, or other professional who knows or is able to ascertain sufficient knowledge of the applicant’s condition, may complete the eight questions (Level I) on this specific form. (See Chapter 2.5.)

Under Indiana’s PASRR program, only the following entities are authorized to conduct

PASRR evaluations:

- CMHC: The Indiana licensed Community Mental Health Centers (CMHC) are the agencies authorized to complete PASRR/MI Level II Mental Health Assessments for PAS and RR as follows:
  a) the CMHC serving the area in which the individual is located will complete the Level II assessment; except that for
  b) residents of a State Psychiatric Hospital, the CMHC which has gatekeeper responsibility for the individual has primary responsibility for completion of the PAS/PASRR Level II.

  The gatekeeper CMHC:
  a) has the option to defer completion of the Level II to the closer CMHC which serves the locality of the State Psychiatric Hospital, e.g., when geographic distance makes completion of a Level II impractical and/or cost prohibitive;
  b) must work out details of the deferral with the local CMHC to assure that the federal PAS timeliness requirement is met; and
  c) must assure that the referring IPAS agency is notified, in writing, when a gatekeeper CMHC which is not also the local CMHC is responsible for the Level II.

- Indiana Hospitals: Under specific circumstances, a hospital is also authorized to conduct a PASRR/MI Level II Mental Health Assessment. All requirements for the Level II Assessment must be met, including:
  a) the assessed individual is receiving care in the hospital's acute care inpatient bed and needs transfer into a Medicaid-certified non-acute care (nursing facility) bed or unit; and
  b) all areas of the PASRR/MI Level II Mental Health Assessment are:
     1. thoroughly completed, meeting PASRR/MI standards;
     2. signed and dated by a certified social worker on page 2; and
     3. certified by a board-certified or board-eligible psychiatrist on page 4; AND
  c) the individual is not being admitted into a non-acute bed in which the hospital has an interest or affiliation.

11.2.2.4 PASRR/MI Assessment Forms

- The Assessment of Mental Health form (State Form 43064/BAIS 0036) (see Appendix Z) is the established format for documenting the PASRR/MI mental health portion of the Level II.

- The Inappropriate Referral for Level II Assessment form (State Form 47180/BAIS 0028) (see Appendix BB) may be completed and issued by a CMHC in lieu of the PASRR/MI Level II assessment. (See Chapter 13.3.2.)

- The Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment form (State Form 47183/BAIS 0030) (See Appendix AA):
  a) must be completed by the assessor as soon as an assessment is done;
  b) will record the Level II findings and recommendations prior to review and certification by the psychiatrist;
  c) meets federal requirements to provide the assessment findings to the resident, his or her guardian or legal representative, and the NF;
  d) provides a format for the assessor’s exit interview with the NF; and
  e) should be placed on the resident’s chart until the case packet with the final determination is received:
     1) as proof that the Level II assessment was completed; and
     2) for utilization by the NF for patient care planning.

11.2.2.5 PASRR/MI Referral Termination

At any point that a PASRR Level II is terminated prior to completion, the CMHC must document the reason that it was not completed on the Level II “Inappropriate Referral” form (see Appendix BB).

- Use of the “Inappropriate Referral” form is reserved for the CMHC only. When appropriate, the completed “Inappropriate Referral” will be processed in lieu of a

PASRR/MI Level II. It may be used to document:

a) why a required PASRR/MI Level II is not completed;
b) why a referral for PASRR/MI Level II from the IPAS agency is deemed to be unnecessary; and
c) situations when PASRR/MI Level II is deferred until a later date, including an explanation of the individual's condition and a caveat holding the NF responsible to monitor the resident and make referral for Level II as soon as the resident can participate. (For example, an individual in delirium or a comatose state cannot be assessed until the condition clears or ameliorates enough for the individual to participate in the interview.)

11.2.2.5 PASRR/MI Assessments by Hospital

To expedite discharge and avoid delays, an acute care hospital may choose to complete the PASRR/MI Level II assessment.

As part of its discharge planning, each hospital:

a) should identify patients at risk of possible NF placement as soon as possible following admission;
b) through an "early warning system" implemented for those inpatients who will require IPAS and/or PASRR assessment.

To complete the Level II, the hospital should follow directions on the Level II: Mental Health Assessment form itself and this Manual.

- For PAS, the hospital should:
  a) FAX the Level II and other IPAS documents directly to the IPAS agency; and
  b) immediately mail or deliver the originals to the IPAS agency; and
  c) provide copies to the chosen NF.

- For RR, the hospital will need to identify whether PASRR Level II is needed prior to or after NF readmission. (See Chapter 14.1.4.2.)

When Level II is required prior to return to a NF, the hospital may:

a) complete the PASRR/MI Level II; or
b) make a referral directly to (or have the NF contact) the local CMHC to complete the Level II. (See Chapter 14.2.4 for procedures to notify the CMHC to do a Level II).

If the hospital completes the RR PASRR/MI Level II, it should:

a) assure that the case documents include, at a minimum:
   1) a cover sheet or letter of explanation;
   2) a new 450B Physician Certification for Long-Term Care and/or other medical documentation to support need for NF level of services;
   3) the PASRR/MI Level II Assessment of Mental Health (completed by the hospital);
   4) a copy of the Form PAS 4B or a "state-certified" Form 450B, Physician Certification (obtained from the NF from which the individual was admitted); and
   5) other documentation deemed pertinent and necessary; and
b) FAX the Level II assessment and other required documents directly to the State PASRR/MI Unit.

THE HOSPITAL MUST IMMEDIATELY MAIL THE CASE HARD COPIES DIRECTLY TO THE DESIGNATED NF.

- NOTE: Failure of the hospital to send the case hard copies to the NF may jeopardize future acceptance of faxed cases from that hospital. Furthermore, the NF may be in jeopardy of denial of reimbursement and in noncompliance with program requirements.

Upon receipt of a faxed PASRR/MI RR case, the State PASRR Unit will:

a) immediately review the case record; and
b) return FAX the RR determination to the NF designated by the hospital. (Sometimes verbal approval will be given by telephone pending issuance of the determination form.)

When the hospital also wants a copy of the determination, it should make a clear note to that effect on its FAX cover sheet, including the hospital's FAX number.

11.2.3 PASRR/MR/DD or PASRR/MI/MR/DD

For individuals with a condition of MR/DD and MI/MR/DD, the second part of the evaluation is the PASRR/MR/DD or PASRR/MI/MR/DD evaluation.

ONLY the contracted Diagnosis and Evaluation (D&E) Teams are authorized to perform the PASRR/DD Level II.

When collateral information appears to support that the individual is not MR/DD, the IPAS agency should:
a) provide this information to the D&E Team when the referral for Level II is made;
b) including information about completion of school, an independent work history, raising a family, or other life accomplishments not usually ascribed to individuals with MR/DD.
It may help the D&E Team expedite a determination of whether the individual meets the criteria for developmental disability.

11.2.3.1 Definition of MR/DD

For purposes of PASRR, a suspected condition of MR/DD or MI/MR/DD always requires review by the BDDS Field Office to determine whether an individual meets the qualifications for having a condition of developmental disability. This certification must be documented in writing.

An individual is considered to have a condition of mental retardation/developmental disability if he or she:
a) has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition, other than mental illness, closely related to mental retardation in that the impairment of general intellectual functioning or adaptive behavior are similar to that of mental retardation; and
b) the condition manifested itself prior to age 22, is likely to continue indefinitely, and requires that the person have 24-hour supervision; and
c) as a result of the condition, the person has substantial functional limitations in three or more of the following major life areas: self care, understanding and use of language, learning, mobility, self direction, capacity for independent living.

When an individual is:
a) determined to be not MR/DD; but
b) has or is suspected of having a condition of serious MI;
referral for PASRR/MI Level II by the CMHC must be done.

- NOTE: The case record must include the MR/DD certification that the individual is not MR/DD and the NF should maintain it on the resident's chart.

11.2.3.2 Dual Diagnosis (MI/MR/DD)

An individual is considered to have a dual diagnosis if he or she has both MI and MR/DD. The MR/DD condition is always considered to be the primary condition for PASRR purposes. These individuals must always be referred to the D&E Team for the MR/DD Level II.

11.2.3.3 Designated MR/DD Assessors

Federal law and regulations cited in Chapter 12.2.2.4 also apply to assessors for MR/DD and/or MI/MR/DD assessments and determinations.

In Indiana the designated and contracted entity to perform MR/DD evaluations is the local D&E Team working with the local BDDS Field Services offices.

11.2.3.4 PASRR/MR/DD Assessment Forms

In addition to the forms required for IPAS, the PASRR/MR/DD portion of the Level II requires the following forms for PAS and for RR.

- The "Pre-Admission Screening/Resident Review Certification for Nursing Facility Services" (State Form 46922(R/2-98)/BAIS 0024) provides a summary of the PASRR/MR/DD determination certification. It must accompany the other documents listed here and will

usually be placed on top.

- A multi-page electronic form, titled “Case Analysis: Preadmission Screening” or “Case Analysis: Resident Review,” is the PASRR/MR/DD portion of the Level II. The number of pages may vary according to the individual’s condition and identified needs.

- The “Certification By Physician for Long-Term Care Services and Physical Examination for PASRR Level II” (State Form 45278(2/92)Form 450B/PASARR2A - Section VI) provides supplemental medical information required by 42 CFR 483.136.

- “Definition of Specialized Services for PAS/ARR” (State Form 46921(3/95)/BAIS 0023) is an optional form used to record the Level II service(s) findings. If the form is not used, the information, which it would have identified, must be recorded elsewhere in the D&E assessment.

11.3 SPECIALIZED SERVICES (SS)

Specialized Services are intensive services identified through the Level II Assessment that are needed to address certain identified needs related to an individual's condition of MI and/or MR/DD. These services are of a duration and/or intensity that they are not typically provided within or by a nursing facility. Listed below is the definition of PASRR Specialized Services as defined in Indiana's Medicaid State Plan.

11.3.1 Definition of SS

As defined in the Indiana State Plan Amendment 1-1-93 under Title XIX of the Social Security Act, “specialized services are those services identified through the Level II Assessment which are required to address the identified needs related to the person’s developmental disability and/or mental illness….” See the back of Appendix C.)

NOTE: See Chapter 16 for directions and conditions under which the “30-month” rule and choice of setting in which to receive Specialized Services apply. Very specific criteria must be followed before ascribing the PASRR 30-month parameters.

For MI: Specialized services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital.

For MR/DD: Specialized services for MR/DD may include, but are not limited to, short term inpatient psychiatric care, long term psychiatric care, supported employment, supported employment follow-along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement.

11.3.2 Services of Lesser Intensity than SS

Specialized Rehabilitative Services are those services identified through the Level II assessment which are required to address one’s identified needs as a result of their developmental disability and/or mental illness. These services are less intensive than “Specialized Services” and can be provided in a NF or under contract with outside sources.

These services are less intensive than "specialized services" and must be provided by the NF to all residents who need such services. They are identified through the Level II assessment for MI and/or MR/DD and specified through the final determination. These services may be provided in the NF by qualified NF staff or under contract with outside resources.

11.4 LEVEL II CASE PACKET

For each PASRR Level II, the CMHC or D&E Team/BDDS Office will prepare a packet of case documents. The case packet will be distributed as follows.

11.4.1 PAS and RR

- For PAS (See Chapter 13 for a list of documents.):

a) PASRR/MI: The CMHC will provide the case packet to the local IPAS agency; and
b) PASRR/MR/DD: The D&E Team will provide the case packet to the appropriate BDDS Office, which will process and forward it to the local IPAS agency.

- For RR (See Chapter 14 for a list of documents.):

c) PASRR/MI: The CMHC will send the case packet to the State PASRR Unit; and
d) PASRR/MR/DD: The D&E Team will send the case packet to the local BDDS Field Office.

- NOTE: For RR, the CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF to support need for NF level of services. When documentation is not sufficient, the State PASRR Unit will contact the NF to resolve discrepancies or get additional information.

There may be private-pay residents who have never had need for NF level of services determined by Medicaid, IPAS or PASRR because:
a) they were admitted under IPAS penalty for refusal to participate; and/or
b) have had a significant-change in condition for MI following NF admission; and/or
c) were missed under IPAS; and
d) have neither a Form PAS 4B or State-certified Form 450B.
The CMHC or D&E Team assessor should contact the State PASRR Unit to determine how to meet this documentation need for the case packet.

- NOTE: "Current" means that the resident's condition on which the document is based remains the same and has not changed.

11.4.2 MI Summary of Preliminary Findings

At the conclusion of each MI Level II mental health assessment, the CMHC assessor will:
a) explain the findings to the individual;
b) complete the "Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment" (See Appendix AA.);
c) give a copy of the Summary of Preliminary Findings and Recommendations to the NF resident (and, if indicated, family, guardian, or personal representative); and
d) give a copy to the NF at the exit interview.
The CMHC assessor will use it to explain the assessment findings and answer questions.

The NF will:
a) provide a copy to the NF resident, if needed;
b) use the Summary of Preliminary Findings and Recommendations for resident care planning; and
c) place it on the resident’s chart until the final MI RR case packet is received.

11.4.3 MI CMHC RR Referral Checklist

For MI, the CMHC RR Referral Checklist form will assist the CMHC to document planning and scheduling activities for Yearly RRs, collect essential tracking data, and list cases submitted to the State PASRR Unit. Information on the Checklist form also provides data essential for initial state entry. The CMHC will:

a) complete the CMHC RR Referral Checklist form (Appendix EE) [except Column #12];

- NOTE: In Part 4, check status by substituting "Yearly" for "Routine," and "Significant-Change" for "Non-Routine". The date for "Routine" should be entered as "N/A."

b) obtain the date of the most recent Level II assessment, if one has been done, and enter the date of the psychiatrist's signature in Column #9. This information should be available from the CMHC files or from the NF chart;

- NOTE: If no record of a prior Level II can be found, the CMHC should make an explanatory notation in Checklist Column #9, "Date Last L-II Assmt," specifying the reason: "Prior Level II Not Required," "Prior Level II Required and Completed - But Missing," "Prior Level II Required - But Never Referred or

Completed," "Resident Transferred, But NF Did Not Notify CMHC." If none of these apply, or more explanation is needed, the CMHC should enter a brief explanatory phrase as necessary.

c) after the Level II assessment is completed, enter the date of the psychiatrist's signature in Column #12;

- NOTE: A comparison of Columns #9 and #12 on the CMHC RR Referral Checklist will verify whether the RR time limit is in compliance;

d) attach a copy of the CMHC RR Checklist to the RR case(s) prior to submission to the State PASRR Unit.

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 12
PASRR DETERMINATIONS AND APPEALS

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 12
PASRR DETERMINATIONS AND APPEALS

Based on Level II findings contained in the PAS and RR case documentation materials submitted to the State for review and determination, the State MI or MR/DD authority will issue a determination of:
a) whether an individual requires the level of services provided by a NF;
b) whether specialized services are needed; and
c) if NF is approved, whether MI and/or MR/DD services of lesser intensity than specialized services are needed.

12.1 PASRR DETERMINATION CRITERIA

At a minimum, the PASRR Level II assessment process will result in the following findings:
a) the individual does/does not have a need for NF level of services;
b) the individual has/does not have a condition of MI and/or MR/DD as defined for PASRR purposes;
c) the individual does/does not need specialized services as defined for PASRR purposes; and
d) the individual does/does not need services of a lesser intensity for his/her condition of MI and/or MRDD, specifying the particular service needs.

12.1.1 Determination Authorities

The following entities are authorized to make the final PASRR determination:
a) for all PAS and MI-RR, the State PASRR Unit will review Level II case packets and make the final determination; and
b) for MR/DD-RR and MI/MR/DD-RR cases, the local D&E Team will review Level II case packets and make the final determination.

12.1.2 Appropriate Placement

Placement of an individual with MI and/or MR/DD in a NF is considered appropriate only when:
a) the individual's needs are such that he or she meets the minimum standards for NF admission or residence; and
b) the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted.

Determinations regarding appropriate placement will be made:
a) on an individual basis, taking into account the needs of the individual; and
b) following application of the criteria:
   1) under 450 IAC 1-3-1 and 1-3-2 for MI; and
   2) under 450 IAC 1-3-1 for MR/DD.

A caveat may be entered on the IPAS 4B Determination Form concerning placement needs when an individual requires specific service consideration, for example, care in an Alzheimer's Unit, problem behaviors, or monitoring for possible suicidal ideation.

12.1.3 Placement Categories

All determinations, both categorical and final, will be recorded in the resident's NF record.

- Categorical Determination

Categorical determinations are those decisions which take into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a NF is normally needed, and that provision of specialized services is not normally needed. Advance group categorical determinations include Exempted Hospital Discharge, Respite Care and APS. (See Chapter 13.)

The NF will maintain copies of the documents authorizing temporary admission on the individual's chart:
a) Level I;
b) PASRR Categorical Determination for Respite and APS (Appendices U and W) form; and
c) Application for Long-Term Care Services.

NOTE: Requirements for these categorical determinations differ from the categories of temporary admission under Indiana's IPAS program. They are more restrictive and require authorization on specific PASRR forms.

- Individualized Determinations

Individualized determinations are those decisions based on more extensive individualized evaluations. These individualized determinations include (a) the evaluation and findings of need for NF level of services (PASRR/NF); and (b) whether an individual with MI (PASRR/MI) and/or MR/DD (PASRR/MR/DD) requires specialized services.

- Final Determination

The PASRR final determination for individuals with MI will be made:
a) by the designated State mental health authority (State PASRR Unit); and
b) be based on an independent physical and mental evaluation performed by a person or entity other than the designated State mental health authority.

The PASRR final determination for individuals with MR/DD will be made by the designated State MR/DD authority (State PASRR Unit), without any requirement for independent evaluation other than the D&E Team.

The final determination is:
a) (or PAS) included on the PAS/PASRR Assessment Determination Form 4B; and
b) (for PASRR/MI RR) issued in the form of an RR Determination Letter; and
c) (for PASRR/MR/DD RR) issued as a certification form and an RR Determination Letter.

NOTE: The NF should maintain all IPAS/PASRR documentation in the same section of the resident's chart, including, but not limited to, the IPAS application, Level I, Level II, other assessment documents, PAS 4B, RR Determination Letter, etc.

12.1.3.1 PAS/PASRR Determinations

Can be admitted to a NF if the applicant has been found:
1) to meet the requirements of need for NF level of services under 450 IAC 1-3-1 or 1-3-2 (See Chapter 4.6.1.); and
2) does not require specialized services (See Chapter 13.5.).

Cannot be admitted to a NF: the applicant has been determined to NOT meet the requirements for NF need for care, regardless of the need for specialized services.

12.1.3.2 RR/PASRR Determinations

a) Can be considered appropriate for continued placement in a NF when the resident:
1) has been determined to meet the need for NF level of services; and
2) does not need specialized services;

b) Cannot be considered appropriate for continued placement in a NF and will be discharged to an appropriate setting when the resident:
1) does NOT have a need for NF care; and
2) has resided in a NF for less than 30 consecutive months (short-term residents);
3) regardless of the need for specialized services.

c) Cannot be considered appropriate for continued placement in a NF and will be discharged, regardless of the length of his or her stay (short or long-term residents), when the resident:
1) does NOT have a need for NF level of services; and
2) does NOT require specialized services.

d) For MR/DD residents, may choose to remain in the NF even though the placement would otherwise be inappropriate when the resident:
1) does NOT have a need for NF level of services;
2) but DOES require specialized services; and
3) has continuously resided in a NF for at least 30 consecutive months before the date of determination inappropriate (long-term resident). The resident may choose to continue to reside in the facility and receive specialized services, or to receive specialized services in an alternative appropriate institutional or noninstitutional setting. (NOTE: For persons meeting this requirement who choose to remain in the NF setting, specialized services will be provided in the

NF.)

e) For MI residents, specialized services are equivalent to provision of inpatient psychiatric care and are not typically provided within or by a NF due to the duration and/or intensity of the MI specialized services.

12.1.4 Level II and MDS

Federal regulations require that:

a) the CMHC or D&E Team review the NF Minimum Data Set and Resident Assessment/ (MDS and RA) as part of the PASRR Level II assessment; and

b) the NF utilize the PASRR Level II with the resident's individualized plan of care for residents with MI and/or MR/DD conditions.

Combining these two processes will produce a more comprehensive, multidisciplinary approach to the individual's care plan. It is the NF's responsibility to assure that the Level II and the MDS assessments are used interactively. The MDS is updated quarterly or with a significant change in the resident's condition or treatment.

The CMHC or D&E Team should:

a) review and utilize information and documentation available at the NF, including the RA/MDS, for purposes of the Level II assessment;

b) bring conflicting or inaccurate information to the attention of the NF and discuss it with them.

NOTE: The NF, with the attending physician and/or NF medical director, will need to reconcile discrepancies between the NF's charted MI diagnosis and the diagnosis determined by the Level II assessment. The physician should feel free to contact the Level II assessor or psychiatrist at the CMHC to discuss questions or concerns.

12.1.5 Level II Termination

- For PAS: The PAS/PASRR case:

a) may be terminated at any point it has been determined that there is no need for NF level of services; and

b) for applicants who are determined to not need NF level of services, the specialized services determination does not need to be made. (See Chapter 5.2.)

NOTE: For MR/DD cases, however, there must always be a finding of both need for NF level of services and need for specialized services.

- For RR: An RR/PASRR case may NOT be terminated as soon as it is found that there is no need for NF care. The determination for RR must always include both parts:

a) a determination of need for NF level of services; and

b) a finding of need for specialized services.

Cases may also be terminated early due to, but not limited to, the following reasons:

a) death prior to determination;

b) transfer to another NF;

c) written voluntary withdrawal of the application for NF admission; or

d) refusal to cooperate in a timely manner (within the legally defined time frames for case processing and determination).

NOTE: Regulations state that a Medicaid-certified NF must not admit or retain any individual who requires PASRR Level II, but has not had one. Therefore, an individual cannot refuse Level II and remain in a NF. When an individual or his representative refuses to cooperate in Level II, the Level II assessor should immediately notify the NF DON or administrator of the individual's refusal, and the NF should counsel the individual or representative on the consequences of refusal.

Any termination of the PASRR Level II assessment must be clearly documented in the case record. PASRR/MI cases will use the "Inappropriate Referral" form and submit it to either the IPAS agency or State PASRR Unit, as appropriate.

When an IPAS case is terminated after referral for Level II has been made:

a) the IPAS agency should immediately notify the CMHC or D&E Team of the case status; and

b) the Level II assessment should also be terminated at the point notice is received from the IPAS agency; and

c) whatever documentation has been completed will be retained in the file.

12.1.6 NF Retention of Level I and Level II

Federal regulations require that:

a) the NF receive a copy of any applicable Level I screen, with the certification of for need for Level II at the bottom; and/or
b) the Level II assessment with all supporting documentation; and
c) the PASRR Letter/Certificate of Determination; and
d) retain them on each resident's chart;

12.1.7 Transfer of Level I and Level II With Resident

Resident transfers, with or without an intervening hospital stay, require transfer of the most current Level I and Level II assessment documentation to the new, admitting NF.

It is the responsibility of:

a) the prior NF to provide copies of these assessments to the new NF; and
b) the new or admitting NF to request and review these assessments as part of the admission, MDS, and care planning processes.

12.1.8 Time Limit Level II Determination Is Effective

The PASRR Level II assessment and findings are effective until there is a substantial change in the applicant’s or resident’s:

a) MI mental health condition; or
b) MR/DD functioning status or medical condition.

- For PAS-MI, however, the IPAS assessment and determination finding is:
  a) only effective for ninety (90) days from the date of the PAS 4B Notice of Determination; and
  b) must be updated or redone when an individual is not admitted to a NF within ninety (90) days of the PAS 4B issuance. (See Chapter 5.5.)

- For PAS-MR/DD, the Level II assessment and determination are effective for one (l) year, unless there has been a substantial change in functioning status or medical condition.

When the ninety (90) days has expired, the applicant or NF will contact the IPAS agency to update or complete a new IPAS assessment and finding. For PASRR cases, the IPAS agency will:

a) review whether there has been a significant change in mental and/or MR/DD condition;
b) if no change, the IPAS agency will document its finding; and
   1) indicate that the information contained in the Level II is current to the individual’s condition on page 1 of the MI Level II; and
   2) resubmit the case record for a PASRR determination; but
c) if there is a change, the IPAS agency will provide the information to the CMHC or D&E Team, which will decide:
   1) whether a new Level II should be completed; or
   2) whether sections of the Level II should be updated; or
   3) that another Level II is not needed and whether to:
      i) issue an Inappropriate Referral form or letter/statement; or
      ii) have the IPAS agency update the original PASRR/MI Level II assessment by certifying, "No change" or "Remains Same," with the reviewer's initials, affiliation, and date of certification prominently entered at the top of the first page.

When a new Level II is required, the IPAS agency will make a clear notation on page 1 of the new Level II showing that this is a reassessment and the reason for it.

- For RR, the Level II assessment and determination remain effective until the individual, MI and/or MR/DD, has a significant change in mental status and/or MR/DD condition. (Also see Chapter 14 of this Manual.)

12.2 APPEALS, RECONSIDERATIONS, AND JUDICIAL REVIEW

An individual has the right to:

a) "appeal" an adverse action and request a fair hearing when he/she disagrees with the PASRR determination; and/or
b) request a "reconsideration" of an adverse finding when there is documentation pertinent to the reason for the denial which was not previously submitted.

Reconsideration using additional documentation follows a process similar to that for the original decision and can be processed more quickly than an appeal. An appeal, however, is a separate, formal process which usually requires more time. An appeal reviews whether the determination was correct based on the documentation submitted.

12.2.1 Reconsideration

An individual may request “reconsideration” of an adverse finding:
a) using pertinent case documentation, not previously submitted, provided after the final determination;
b) submitted by the applicant or the NF and/or attending physician acting on behalf of the individual;
c) requested as soon as the additional documentation is identified, but no later than within thirty (30) days of the effective date of the determination.

When there is documentation, it may be advisable to request both an appeal and reconsideration at the same time, due to the 30-day time constraint for filing an appeal request. Reconsideration does not replace the appeals process, but may enhance it.

When reconsideration upholds the original adverse finding, an appeal will already be in process and time is not lost. If, however, the reconsideration reverses the original determination, the Hearing and Appeals Section will be notified to cancel the appeal.

Reconsideration is requested:
a) for MI: through the IPAS agency for need for NF level of services (Level of Care) issues; and
b) for MR/DD: through the BDDS Field Office for issues involving specialized services;
c) by resubmitting:
   1) the entire original IPAS case record;
   2) with new documentation clearly flagged;
   3) to the State PASRR Unit;
d) clearly marked as a "Request for IPAS/PASRR Determination Reconsideration."

12.2.2 Appeals

Information on filing an appeal is printed on all determination notices for PAS and RR:
a) for PAS, it is on both the front and back of the PAS 4B form (Appendix P); and
b) for RR, it is in the body of the RR Determination Letters (Appendix HH).

The appeal request will be submitted within thirty (30) days of the date of the determination notice.

An appeal is requested:
a) by sending a letter:
   1) with the individual's signature;
   2) to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, 402 W. Washington Street, Room W-392, Indianapolis, Indiana 46204;
b) containing:
   1) the individual's address and a telephone number where he or she can be contacted; and
   2) a copy of the notice with the adverse action being appealed.

If the individual is unable to write the letter him/herself, someone may provide assistance in requesting the appeal.

The Division of Family and Children will notify the individual and the IPAS agency which issued the determination in writing of the date, time, and place for the hearing. When the individual has been admitted to a NF in another IPAS agency’s area, the IPAS agency with the case record will forward it to the NF’s local IPAS agency for representation at the hearing.

Prior to, or at the hearing, the individual or his representative has the right to examine the entire contents of the case record.

12.2.3 Representation At Appeal Hearings

The individual may represent him/herself at the hearing or authorize a representative such as an attorney, a relative, a friend, or other spokesman to do so. At the hearing, there is a full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, and question and refute any testimony or evidence presented.

For PAS:

a) the IPAS Agency which has the complete case file will provide case documentation, clarification, and evidence needed upon request of the State PASRR program for preparation of testimony for PASRR appeal hearings; or

b) if the applicant has entered a NF in another IPAS agency's catchment area:

1) the original IPAS agency will forward a copy of all case documents to the NF's local IPAS agency; and

2) the second IPAS agency will provide representation at the hearing;

c) the local OFC Office will act as agent of the Medicaid program representing the PASRR finding at the hearing and

d) OMPP, the State PASRR program, the BDDS Field Office and/or the D&E Team may also provide written testimony for the appeal hearing.

For RR:

a) the local OFC Office will act as agent of the Medicaid program representing the State PASRR determination at the hearing;

b) additional documentation or information may be presented to the State PASRR program:
   1) by the CMHC for support or clarification of the PASRR/MI determination; and
   2) by the D&E Team to address the PASRR/MR/DD determination.

12.2.4 Judicial Review

After exhausting all administrative remedies, the individual may obtain judicial review. Information on how to obtain judicial review will be provided to the individual as part of the appeal determination notice.

12.3 CASE RECORDS

12.3.1 Availability of Level II to Physicians, Hospitals, and Individuals

The PASRR Level II assessment and determination are available to the applicant's or resident's attending physician, the discharging hospital for an individual who has been hospitalized, and the applicant or resident, the guardian or health care representative.

Release of PASRR Level II assessments and notices of determination to attending physicians and staff of discharging hospitals is authorized under Federal Regulations 42 CFR 483.128(l) and 42 CFR 483.130(k). A separate release of information from the patient is not required for pertinent requests.

- Attending Physician: An "attending" physician is considered to be that physician who has primary responsibility for the medical care of the individual.
- Discharging Hospital: The "discharging" hospital is that hospital which provided acute inpatient care and in which the individual currently resides or from which he or she was recently discharged.

Following State review and determination, the complete PASRR Level II case is sent:

a) to the NF for review and retention on the resident's NF chart for individual's admitted to a NF; and

b) to the IPAS agency or BDDS Field Office which processed the Level II case for

individuals who are not admitted to a NF.

These documents are available to the attending physician and discharging hospital for review and/or copying, upon request
a) at the admitting NF; or
b) for individuals who are not admitted to a NF, at the IPAS Agency or BDDS Field Services Office which processed the Level II case.

The NF has the responsibility to:
a) make the Level II evaluation and determination part of the Resident Assessment/Minimum Data Set (RA/MDS) and care planning/case conferencing process; and
b) provide the Level II evaluation and determination information to the individual or resident and his or her legal representative for RR.

For PAS, the IPAS agency will provide to the individual or resident and his or her legal representative this information with a copy of the Level II case materials, as appropriate, with the results of the PASRR Level II assessment and determination.

12.3.2 Confidentiality of Case Records

All authorized entities with access to IPAS/PASRR case records must maintain confidentiality following all pertinent state and federal laws and regulations.

12.3.3 Disposition of Case Records

At the conclusion of the PASRR determination, the appropriate entity must assure that the entire case record packet on which the PASRR determination is based is sent to the appropriate NF.

When the case record is faxed, the State PASRR Unit will send only a copy of the final determination:
a) PAS 4B form, to the appropriate IPAS Agency; and
b) RR determination letter, to the CMHC or D&E Team/ for RR;
for inclusion in the agencies' case file. The D&E Team will forward a copy to the BDDS Field Office.

NOTE: The State PASRR Unit does not retain a copy of the case record. The IPAS agency, CMHC, or D&E Team/BDDS Field Office keeps a copy on file.

For YRR or situations where the original case documents are mailed instead of faxed to the State PASRR Unit, the State PASRR Unit will:
a) fax the determination to the IPAS agency, CMHC or D&E Team; and
b) directly mail the original case record to the indicated NF.

Upon receipt of the determination, the local agency will:
a) put the determination with the case record;
b) make a copy for the agency’s file; and
c) send the entire case record to the applicable NF.

The NF must assure that:
a) the case record and determination are retained on the client's active chart; and
b) if the resident transfers to another NF, a copy of the entire Level II case record is provided to the new NF prior to, but no later than, the time of NF transfer.
The receiving NF must review all pertinent documents addressing a resident's condition, including the PASRR Level II, when determining whether the NF can meet the patient's needs.

12.3.4 Retention of Case Records

The IPAS Agency, CMHC, BDDS Field Office and D&E Team must retain legible copies of all case documents pertinent to the PAS and/or RR portions for which they are responsible for a period of at least three (3) years from the date of most recent case action. For all PASRR cases, the signature date of the designated determination authority will be the determination date. (Also see Chapter 5.8.)

If a reconsideration or appeal is processed, the most recent signature date of the

designated determination authority will be used.

This documentation provides support for future audit purposes. Copies of these materials must be made available to OMPP, the State PASRR Unit, and state or federal surveyors or auditors upon request. As needed, copies of case documentation must be available for appeal hearings or audit purposes.

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 13
"PAS" PORTION OF PASRR

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 13
“PAS” PORTION OF PASRR

PAS is the process used for new admissions only. (Transfers and readmissions are part of the RR process.) "New admission" also includes those situations wherein an individual is discharged from a NF to a community living arrangement and later needs to be readmitted to a NF.

NOTE: To avoid confusion with the "PAS" part of PASRR, Indiana's PreAdmission Screening program is referred to as "IPAS" throughout this Manual.

13.1 ADMISSION REQUIREMENTS

Effective January l, l989, federal regulations prohibit NFs participating in Medicaid from admitting or retaining any individual with mental illness and/or mental retardation/developmental disability who:

a) should have been assessed under PASRR, but was not; or
b) was assessed and determined to be inappropriate for NF placement.

Indiana's PAS program provides part of the PASRR Level II assessment. Individuals may be admitted to a NF when:

a) IPAS program requirements including the PASRR Level II assessment and determination are completed PRIOR to NF admission; or
b) the applicant qualifies under one of the conditions listed in this Chapter for temporary admission, pending completion of the PASRR Level II process.

Planning for NF admission should begin as soon as possible to allow as much time as possible for the necessary screenings and assessments. In particular, hospital units must identify and prepare those individuals who are at risk of NF placement early in the inpatient stay. To wait until discharge is imminent is to risk delay of discharge and placement.

TYPES OF ADMISSION UNDER PASRR (Chapter 13)

Complete Level I

Complete Application for Long-Term Care Services

Complete IPAS and/or PASRR Assessment and Determination PRIOR to NF Admission (See Chapter 13.2)	Suicidal Ideation and/or Danger to Self or Others Level II always required, unless diagnosis of primary dementia (See Chapter 13.4.4)	Level II Exclusions: 1. Dementia (See Chapter 13.4) 2. Exempted Hospital Discharge (See Chapter 13.5.1)	Level II Deferred: 1. Depression Screen (See Chapter 2.5.3) 2. Delirium or Other Severe Medical Condition (See Chapter 13.3) Needs to monitor and refer for Level II if: 1. depression continues ; or 2. severe medical condition improves enough to participate in Level II	Temporary Admission under Categorical Determinations: 1. Respite 2. APS (See Chapter 13.6.1 and 13.6.2)

IPAS AND PASRR PROGRAMS (Chapter 13)

1PAS and PAS of PASRR **RR of PASRR**

Initial Contact at NF, Hospital, Community, AAA, Other

Applies to:
1. Resident of NF; or
2. Inpatient Hospital Acute-Care Bed Admitted from NF

Referral to AAA

Needs Level II **No Level II Need**

Private Pay: No Level II

Medicaid Recipient, Applicant, or Will Apply: No Level II

Needs PAS/PASRR Level II

Prior Level II Completed: May Readmit to NF with new Level II after Readmission

Hospital Completes Level II (MI Only): Send To:

May Readmit Directly to NF

AAA Makes Final Determination (Note: Denials Sent to OMPP)

OMPP Makes Final Determination

Refer for Level II to:

- CMHC for MI
- D&E Team for MR/DD or MI/MR/DD

NF will Forward to:

State PASRR Unit Makes Final Determination

Send PAS RR to AAA

Final Determination

NF Placement Is Appropriate

NF Placement Is Denied For:

- No Need for NF Level of Services
- Needs Specialized Services Not Available in NF
- Available Community/In-Home Services to Meet Needs

Denials May Request:

- Reconsideration; and/or
- Fair Hearing Through Medicaid Appeals Process

13.2 LEVEL I: IDENTIFICATION SCREEN

A Medicaid-certified NF is prohibited from admitting any new resident without completion of the PASRR Level I: Identification Screen PRIOR to admission. (See Appendix U.)

NOTE: EVERY completed Application for Long-Term Care Services form (PAS Application form) must have an appropriately completed Level I form attached prior to submission to the PAS Agency.

13.2.1 Level I: Purpose and Completion

The Level I: Identification Screen consists of eight (8) questions designed to identify whether an applicant has, or is suspected of having, a condition of MI and/or MR/DD. All eight questions should be carefully read and answered.

The Level I form is used as:
a) the primary identifier of need for Level II assessment;
b) the certification of temporary NF admission under Exempted Hospital Discharge (middle of the form); and
c) the Certification of Need for Level II (bottom of the form).

The Level I may be completed by any professional individual who:
a) has sufficient knowledge of the applicant and his condition to be able to answer the eight questions;
b) will sign the Level I screening form, giving title/position and the date of completion; and
c) will check the box beneath the signature which designates the person's position.
If a hospital discharge planner or NF staff member completes the Level I, the name of the hospital or NF with which the person is affiliated should be entered.

The Level I Decision-Making Protocol (see Appendix F) and the Screen for Depression (see Appendix V) are tools to provide guidance in making this decision.

the Level I should be completed PRIOR to application for IPAS In order to decide whether an applicant can refuse to participate in IPAS. If the Level II is required, the applicant must NOT check "refuse to participate" on the LTC application form and be admitted to a Medicaid-certified NF, even under the PAS penalty.

13.2.2 Other Indicators

The following identifiers of need for Level II assessment may also apply:
a) recent suicidal and/or homicidal ideation; and/or
b) recent or current residence in a state psychiatric hospital or MR/DD facility (including Indiana or any other state), regardless of known diagnosis (including dementia); and/or
c) currently receiving services from a CMHC for a serious mental illness (MI) condition, as defined by the PASRR/MI program, or from a provider of MR/DD services; and/or
d) other documentation, such as a hospital discharge summary, 450B form, etc.

Information may either supplement or contradict the information on the Level I. The IPAS agency should:
a) investigate and reconcile any discrepancies;
b) note the findings on the Level I form and explain it in the case record; and
c) immediately initiate the Level II assessment.

Whenever the IPAS agency decides that Level II is or is not required contrary to responses on the Level I, the reason must be clearly and thoroughly documented in the case record.

NOTE: At any point that it is identified that an individual requires PASRR Level II assessment but has not had one, regardless of the responses on the Level I or prior findings (such as a prior PAS 4B), the PASRR Level II assessment must be completed. (Also see Chapter 12.)

13.2.3 Certification of Need for Level II

For all new admissions the IPAS agency, acting as an entity independent of the NF, must:
a) review EVERY completed Level I form;
b) determine the need for further assessment under Level II;
c) certify the need for Level II assessment with either "yes" or "no" that Level II is or is not needed;
d) enter its certification on the bottom of the Level I form; and
e) retain a copy as part of the permanent record.

13.2.4 Notice To Applicant/Resident

First time positive results which indicate a need for Level II require written notice to the applicant, or his or her legal representative that referral will be made for Level II assessment.

For PAS, the IPAS agency will issue a written notice that:
a) the applicant has been identified as having, or is suspected of having, a condition of MI and/or MR/DD; and
b) is being referred to the State MI or MR/DD authority for Level II assessment. (See Appendix X.) for the format to be used.)

For RR, the NF will provide the written notice to a resident (who has been identified for the first time for a referral for Level II assessment), his/her legal guardian and/or legal representative, that:
a) the resident has been identified for Level II assessment based on a suspected condition of MI and/or MR/DD; and
b) is being referred to the State MI or MR/DD authority.

13.2.5 Referral for Level II Assessment

Level II Mental Health Assessment is completed by the:
a) Community Mental Health Center (CMHC) for individuals with a MI condition; and
b) Diagnostic and Evaluation (D&E) Team for individuals with:
   1) a condition of MR/DD; or
   2) a dual diagnosis of MI and MR/DD (MI/MR/DD). See Chapter 13.2.1.

Referral for Level II is made:
a) for PAS, by the local IPAS Agency to the CMHC or D&E Team, as appropriate; or
b) for RR, by the NF directly to the CMHC or D&E Team for Significant-Change RR. See Chapter 12.

For residents of a State psychiatric hospital, the responsible staff person of the hospital will:
a) coordinate the proposed transfer to a NF with the designated gatekeeper CMHC;
b) obtain a letter from the gatekeeper CMHC stating whether there is concurrence with the proposed NF transfer;
c) initiate contact with the IPAS agency with the request for IPAS assessment, including:
   1) the name, address, and other information on the appropriate gatekeeper CMHC; and
   2) the following completed forms or certifications:
      i) Level I form;
      ii) Application for Long-Term care Services;
      iii) Certification letter by the designated CMHC gatekeeper; and
      iv) Form 450B Sections I-III, Physician Certification of Need for Long-Term Care Services.

The IPAS agency serving the area of the hospital will make referral for PASRR/MI Level II assessment to the designated CMHC gatekeeper. Also see Chapters 10.5.5.

13.2.6 PAS Assessment Termination Prior to PASRR/MI Level II Referral

When PAS determines that an applicant with MI:
a) does not to meet the need for NF services criteria; and
b) State PASRR Unit, after conferring with the IPAS agency, concurs;
the PAS/PASRR process may be terminated prior to CMHC Level II referral.

When submitting a PAS case packet to the State PASRR office for the denial determination, the reason for non-referral for PASRR/MI Level II must be clearly documented on the PAS 4A form or in a cover letter.

NOTE: This does not apply for individuals with a condition of MR/DD and/or MI/MR/DD. Also, RR Level II must be completed and a determination made under both NF LOC and Level II assessment.

13.2.7 Routing and Retention of Level I

After completion, the Level I form will be routed as follows:
a) for PAS, the NF or entity completing the Level I must:
   1) attached the Level I form to the Application form and other required documentation;
   2) immediately send a copy of the Level I together with the PAS Application to the PAS Agency which serves its area; and
   3) retain a copy, with the Application form, on the resident’s chart.

NOTE: The Level I and PAS Application must be sent to the PAS Agency for all applicants, including those who do not agree to participate and do not require Level II, but who are admitted to the NF under PAS penalty, within five (5) days of completion.

b) for RR, the NF is no longer required to complete Level I form, but may voluntarily use it as a tool to identify residents with MI.

NOTE: RR referral is now based on the MDS for Significant-Change RR or on CMHC or D&E Team tracking for YRR. See Chapter 12.

For transfers between NFs, the transferring NF must provide a copy of the Level I and Application forms to the receiving NF.

13.3 LEVEL II DEFERRAL DUE TO MEDICAL CONDITION(S)

Level II assessment may be deferred:

a) when an individual is unable to participate due to a condition of severe medical illness (such as delirium, a comatose state, recent traumatic head injury);

b) which makes it impossible for the individual to participate actively in the Level II.

The PASRR Level II will only be deferred until the individual's condition improves enough for a Level II to be completed.

13.3.1 PAS Cases

For PAS cases, the IPAS agency:

a) will gather sufficient information and/or documentation to ascertain that a severe medical condition described above applies;

b) immediately contact the CMHC or BDDS Office to review pertinent information and receive a concurrence of whether the Level II may be deferred;

c) record a narrative explanation in the case record; and

d) specify the decision on the PAS 4A prior to submission of the case to the State PASRR Unit final determination.

13.3.2 RR Cases

For RR cases, the CMHC or BDDS Office will:

a) gather sufficient information and/or documentation to decide whether Level II should be deferred; and

b) if the Level II should be deferred, the finding will be recorded on the Inappropriate Referral form prior to submission to the State PASRR/MI Unit.

13.3.3 State PASRR Unit Action

The State PASRR Unit will:

a) enter the decision on the PAS 4B or the PASRR RR Determination; and

b) include a caveat stating the NF’s responsibility to:

1) monitor the individual’s condition; and

2) make a referral for Level II when the individual’s condition sufficiently improves.

13.4 PASRR/MI DEMENTIA EXCLUSION

The PASRR/MI Dementia Exclusion only applies when an individual;

a) would require Level II due to a condition of serious MI; but

b) has a condition of dementia (including Alzheimer's Disease and related conditions) which is of a degree of severity which is primary over the serious MI; and

c) does NOT have any condition of MR/DD.

NOTE: It is important to understand that the Dementia Exclusion can only be applied to PASRR/MI. Persons who are MR/DD or dually diagnosed as MI/MR/DD do not qualify for this exclusion and must be assessed under Level II.

In order to apply the Dementia Exclusion, the evaluator must:

a) consider all applicable diagnoses of the individual (not limited to those diagnoses specific to a particular crisis or hospitalization);

b) differentiate the level of severity of the dementia and that of the MI condition; and

c) ascertain which is primary/principle.

Generally, levels of dementia are divided into "mild, moderate, and severe." A mild dementia, for example, would not supersede a condition of schizophrenia whereas a severe dementia may be found to be primary over the schizophrenia.

NOTE: For PASRR program purposes, “diagnosis” refers to the individual's overall mental and physical condition. Ranking of diagnoses as primary/principle, secondary, and so forth should be made in this context. Listings of diagnoses must be current to the date of the documentation. The “date of onset” will help establish the rank of a conditions or diagnosis.

13.4.1 Level I Form and Dementia Exclusion

To apply the Dementia Exclusion, Question #1 on the Level I must be answered accurately. (See Appendices F and U.) Question #1 is actually a three-part question:

a) “Does the individual have a documentable diagnosis of senile or presenile dementia (including Alzheimer’s Disease or related disorder) based on criteria in DSM-III-R [or current DSM]…”
b) “…without a concurrent primary diagnosis of a major mental illness or…”
c) “…[without] a diagnosis of mental retardation or developmental disability?” (Words in brackets were added for clarification.)

Question #1 can only be checked “Yes” when all three conditions are met.

The following criteria then applies:

a) Question #1 is "Yes" and all other answers are "No:" neither Level II or dementia documentation are required; or
b) Question #1 is “Yes” and any Question #2-#5 is also “Yes:” the dementia exclusion applies and Level II is not required and the NF must document the dementia. (See Appendix for the Dementia Assessment Checklist form.)
c)

CAUTION: Do not answer "Yes" for Question #l when there is also a diagnosis of mental illness which is primary/principal over the diagnosis of dementia.

13.4.2 Dementia Documentation

When the dementia exclusion applies:

a) PASRR/MI Level II must not be completed; and
b) the NF must document the diagnosis of dementia on the NF active chart.

The content of the dementia documentation must be sufficient to:

a) reduce or eliminate the possibility of a misdiagnosis of dementia resulting from a confusion between mental illness and dementia; AND
b) assure that conditions which mimic dementia have been considered and ruled out; AND
c) provide reasonable evidence of the dementia condition.

NOTE: FOR FEDERAL PASRR PURPOSES, THE PHYSICIAN'S SIGNATURE WITH THE DIAGNOSIS ALONE IS NOT ENOUGH TO DOCUMENT THE DEMENTIA DIAGNOSIS.

Dementia documentation should:

a) apply dementia criteria of the current DSM;
b) be based on a good mental status examination;
c) identify the type of testing or assessment done;
d) specify the date of the testing and/or assessment;
e) include a good physical and history;
f) rule out other conditions which may mimic dementia or cause treatable dementia;
g) summarize the results, including a stated conclusion;
h) have a dated signature and the affiliation of the person who performed the assessment; and
i) be dated and signed by the individual’s physician.

The "Dementia Assessment Checklist" form (see Appendix Y) is an optional form developed to assist NFs with the dementia documentation requirement. Sections #1 through #5 include areas which need to be addressed, at a minimum, in any documentation of dementia.

Other forms of documentation may be used instead, including, but not limited to, the following:

a) the findings of a thorough mental status examination focusing especially on cognitive functioning, supported by a thorough history and physical examination;
b) physician's examination and written medical history established over a long period of time showing progressive deterioration, that dementia is the most likely diagnosis, and

that other conditions which may mimic dementia have been considered and ruled out.; (A complete and identifiable summary of the record which addresses these facts would suffice.)

c) although not sufficient by themselves, the interpretation of the results of other testing such as CT Scan, EEG, MRI, etc. may be included and must reflect the organicity of the condition and show dementia; or

d) only as a last resort, when it is unclear whether MI or dementia is predominant, may a Level II assessment be done.

NOTE: When Level II is done, it must be reviewed and certified by the State PASRR Unit before it can be used to admit an individual or as an exclusion from future Level II assessment.

13.4.3 Use and Retention of Dementia Documentation

Do not refer for Level II to document dementia. Whenever applicable, the Dementia Exclusion must be used. It is the responsibility of the NF to:

a) obtain the documentation;

b) retain it on the resident's chart; and

c) provide a copy of it:

1) when state or federal auditors request it; and

2) to a new NF when the resident transfers.

Unless the dementia is a temporary condition and has improved, all future Level I screenings for the resident should reflect the dementia exclusion. The NF should write on each Level I: "Dementia documentation attached," or "...in chart," or "...on file," etc. The NF should clearly tag or mark the dementia documentation for easy identification during audits.

13.4.4 Suicidal Ideation and/or Danger to Self or Others

Only individuals who qualify under the dementia exclusion are excluded from the Level II assessment requirement when there is a threat of suicidal ideation and/or danger to self or others. It is the responsibility of the NF to review and understand the individual's needs and to ascertain whether the NF can meet those needs without danger to the resident, other NF residents and NF staff.

However, when the IPAS agency is aware that suicidal ideation or threats may exist, it should:

a) enter a caveat in the section of the Application form certifying authorization for temporary admission; and

b) enter the caveat on the PAS Forms 4A and 4B, to document and alert the NF that:

"Applicant's behavior of (specify behavior) may present danger to self and/or others. The admitting NF must assure the safety of the applicant, all other residents, and the NF staff."

13.5 TEMPORARY NF ADMISSION

An individual may be admitted for a short, temporary stay in the NF under:

a) the "Exempted Hospital Discharge" provision; or

b) one of the two (2) determination categories listed below for "Respite Care" and "Adult Protective Services."

NOTE: The only “emergency” admission under PASRR is use of the APS Categorical Determination.

The IPAS agency must assure that the case record and PAS 4A form clearly describes:

a) the type of PASRR categorical determination or hospital exemption used for admission, including applicable dates;

b) requests for extension of an approved temporary authorization, including the reason for extension and the applicable time period;

c) requests for a change of an approved temporary period to a long-term placement, including the change in condition or other reason that permanent placement is now needed and applicable extension dates, when appropriate;

d) changes in status from IPAS-Only to PASRR, including circumstances and type of temporary authorization originally given; and

e) admissions without temporary placement authorization or final determination which have incurred an IPAS Class A infraction.

The appropriate form(s) must be enclosed and the dates of authorized temporary admission clearly shown.

Since available short-term authorizations may not be sufficient to meet the individual's needs, but long-term placement is not needed or sought, the IPAS agency can complete the assessment requesting approval for the anticipated additional time needed. An approval for placement may be requested, for example, for an additional 3-months, 6-months or other identified limit.

13.5.1 Exclusion: "Exempted Hospital Discharge"

PASRR does not allow the IPAS-Only category of "Direct from Hospital" admission. The only allowable NF admission from a hospital acute care bed prior to completion of full PASRR Level II assessment and determination is via the "Exempted Hospital Discharge" provision.

- Definition

An individual may be exempted PASRR Level II for NF admission if the following conditions are met:

a) NF admission directly follows medical treatment in an acute-care non-psychiatric hospital bed; and
b) NF services are needed for the same condition for which the individual received acute hospital care; and
c) less than 30 days of NF care is required, as certified by the attending physician.

NOTE: Not all convalescent care stays from hospitals will be able to fit the prerequisite of less than 30 days duration to recuperate. For those persons, the complete Level II assessment must be completed PRIOR to NF admission. Federal interpretative guidelines give the example of a hip fracture which would normally need more than 30 days to improve and warn NFs to be careful of such admissions.

Medicaid will not reimburse for inappropriate use of the "Exempted Hospital Discharge" exclusion. Such inappropriate use will be noted on the PASRR final determination form.

- Process

PASRR Level I form, Section V - Part A (Appendix S) is used to record the "Exempted Hospital Discharge." The following criteria apply:

a) Section IV of the Level I must be completed;
b) Section V must be completed and signed by the physician, prior to NF admission;
c) the Application for Long-Term Care Services (Appendix L) must be completed (either at the hospital or admitting NF) and attached to the Level I;
d) the NF must retain a copy; and
e) both completed forms must be immediately sent to the IPAS agency.

The NF should also determine the presenting reason for the hospital stay and record it on the Level I form.

The PAS Agency must:

a) review the information;
b) certify the need for Level II referral on the bottom of the Level I; and
c) provide a copy of the certified Level I to the NF for its records and submission to OMPP when Medicaid reimbursement approval is sought.

13.5.2 Longer Stay Requested

When a longer stay is required for convalescence, the NF must:

a) make a referral for a PASRR Level II before the expiration of the 30-day period;
b) send a written explanation of the reason for continued stay directly to the PAS Agency clearly explaining:
   1) the reason the continued stay is needed including why the person did not convalesce within the expected time frame; AND
   2) the anticipated length of additional time needed (e.g.: 30 days, 60 days, long-term placement).

The IPAS agency must:

a) include the letter in the PAS case record;

b) clearly record on the PAS Form 4A the original admission dates and the extension date;
c) provide a copy of the extension to the NF and applicant; and
d) complete the full IPAS/PASRR assessment in sufficient time so that the State PASRR Unit can issue the determination within 40 calendar days of the NF admission.

13.6 CATEGORICAL DETERMINATIONS FOR SHORT-TERM STAYS

Indiana's PASRR only allows for two (2) categories of short-term, temporary NF stay:
a) Respite; and
b) APS 7-Day.
Although the names are the same, there are significant differences between the IPAS and the PASRR versions.

It is noted that these are not exclusions from PASRR, but are determinations that certain PASRR requirements for temporary admission are met. PASRR Level II is only delayed. If an individual needs longer NF placement than the authorized time, the Level II must be completed within the specified time frame.

13.6.1 "PASRR Respite"

An individual may be temporarily admitted to a NF:
a) from home;
b) for a short-term respite care stay not to exceed thirty (30) calendar days per quarter;
c) with a break of at least thirty (30) days between stays of fifteen (15) or more consecutive days of respite care; and
d) with an expressed intention of leaving the NF by the expiration of the approved time period.

- Definition

Respite care is:
a) defined as a temporary or periodic service provided to a functionally impaired individual for the purpose of relieving the regular caregiver;
b) applies to individuals who:
   1) have a caregiver; and
   2) originate from a non-institutional, community-based setting, including foster care homes.

Respite care is not allowed for persons coming from an institution such as a hospital, NF, large ICF/MR, or small MR/DD group home.

- Process

The NF must provide sufficient information for the PAS Agency to make a decision that the applicant qualifies for temporary placement under this provision.

Respite Care stays may:
a) only be authorized by the PAS Agency;
b) PRIOR to the NF admission;
c) on PASRR Form 2A-Section V, Part B (see Appendix W).
The PAS Agency should:
a) send a copy of the PAS Agency's authorization on the appropriate form to the NF to retain on the individual's chart; and
b) issue form PAS 4B, specifying the type of admission and applicable dates.

For Medicaid eligible applicants, the NF will attach a copy of form PAS 4B to it's reimbursement request.

13.6.2 "PASRR APS (7-Day)"

An endangered adult who requires Level II:
- may be admitted temporarily to a NF;
- from home or a non-institutional, community-based setting, including foster care homes (not applicable for persons coming from an institution such as a hospital, NF, large ICF/MR, or small MR/DD group home);
- after being referred to Adult Protective Services (APS) and determined to be an endangered adult under APS guidelines;

- for a period not to exceed seven (7) calendar days while:
  1) the assessment (including the Level II) and determination are made; and/or
  2) alternative living arrangements are made.

NOTE: The only "emergency" admission to a NF under PASRR is under the APS Categorical Determination.

- Definition

An endangered adult is:

* an individual, at least eighteen (18) years of age;
* who is harmed or threatened with harm as a result of neglect, battery or exploitation. (See definition in Appendix B of this Manual.)

- Process

The NF must:

a) must cooperate to provide sufficient information about the individual and the situation for the IPAS Agency to make a determination of whether PASRR APS requirements are met; and
b) immediately send the Level I and Long-Term Care Services Application (PAS Application) to the IPAS Agency.

The IPAS agency:

* is the only entity that can authorize PASRR APS admission;
* will make a decision of whether the applicant qualifies for placement under the APS provision;
* obtain the co-signature of the APS Investigator which attests to the individual's status as an "endangered adult" on PASRR Form 2A, Section V, Part B; (The APS Investigator cannot authorize NF admission.)
* sign PASRR Form 2A, Section V, Part B to authorize temporary admission;
* send a copy to the NF to retain on the individual's chart;
* conduct the entire IPAS/PASRR assessment within seven (7) days of referral; and
* include a copy of the authorization in the PASRR case record submitted to the State.

13.6.3 CCRC 5-Day

The individual using the 5-day stay must be a current resident of the same CCRC in which the transfer is occurring. The Five-Day Transfer Within a CCRC cannot be used for admission of an individual from an outside living arrangement. (See Chapter 3.5.)

- Definition

A Continuing Care Retirement Community (CCRC) is a self-contained, life-care multi-level living arrangement consisting of several settings intended to meet an individual’s needs at various stages of life. (See definition in Appendix B, page 3.)

The purpose of this advance categorical determination is to allow medical treatment for a physical illness and/or to determine if hospitalization is necessary for that illness.

- Process

The process for temporary CCRC 5-Day admission will follow the same guidelines and requirements as those for IPAS. (See Chapter 3.5.1 to 3.5.3 for procedures.)

This temporary admission may not be used for the purpose of assessment or treatment of a psychiatric disorder. At the time of admission, there must be an express intent of leaving the NF by the expiration of the approved time period (5-days).

If the stay is to exceed the time period, the NF must, no later than the fifth (5th) day following admission:

a) take an IPAS Application form and Level I;
b) immediately send or fax the completed forms to the local IPAS agency; and
c) follow the IPAS process.

For purposes of PASRR, such referrals shall be considered preadmission screenings (PAS/PASRR).

13.7 PAS/PASRR TIMELINESS REQUIREMENT

Federal regulations require that a PASRR/PAS determination must be made:

a) as quickly as possible; but
b) no later than within an annual average of seven (7) to nine (9) working days of the referral of an individual by the PAS Agency to the CMHC or D&E Team conducting the Level II.

However, it is evident that entities responsible for meeting this requirement must adhere to tighter time frames in order to assure that the annual average is maintained. The following criteria apply:

a) the CMHCs and D&E Teams must complete the assessment for PAS (and Significant-Change RR) as soon as possible, but no later than six (6) working days to allow for submission to the State; and
b) PAS (and Significant-Change RR) cases must be expedited as quickly as possible, particularly for acute care hospitalized individuals, to avoid unnecessary delays resulting in excessive costs.

The FSSA defines working days as days which are based on the annual holiday calendar issued from the Governor's Office, and the work week is defined as Monday through Friday. In calculating average working days, the first day will be the first full working day following referral from the IPAS agency for PAS (or the NF for Significant-Change RR).

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 14
"RR" PORTION OF PASRR

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 14
"RR" PORTION OF PASRR

14.1 GENERAL

Federal regulations require that each resident of a NF with MI and/or MR/DD receive, at a minimum, a Level II RR at each significant change in mental health or MR/DD condition. Indiana's PASRR program also provides for yearly resident review for certain NF residents.

14.1.1 Types Of RR

Resident Review (RR) is an evaluation and determination for NF residents who:

a) are suspected of having mental illness (MI) and/or mental retardation/developmental disability (MR/DD); and
b) have experienced a significant change in MI and/or MR/DD condition (Significant-Change RR); or
c) are identified by the CMHC or D&E Team/BDDS Office for yearly follow-along through a prior Level II assessment (Yearly RR); or
d) are identified as requiring Level II, but whose timely assessment was missed ("Missed RR") as:
    1) "Missed PAS;"
    2) "Missed YRR;" or
    3) "Missed Significant-Change RR.

14.1.2 Determining Need for RR

Need for RR may be identified by:

a) the NF;
b) the hospital;
c) the CMHC or D&E Team/BDDS Office; or
d) the Medicaid NF Audit Review Team.

Need for RR Level II will be based on:

a) a finding of the prior Level II that Yearly RR is required; or
b) a finding that PAS or RR Level II was required, but was never completed; or
c) a significant change in mental health or MR/DD condition identified by the MDS; or
d) a Medicaid NF Audit Team determination that a Level II is needed.

NOTE: The Level I: Identification Screen form is **only used for PAS**. It is **no longer required for RR** Level II. It is optional for NF use to determine need for RR, and may be voluntarily used to identify residents needing Level II assessment.

If the Medicaid NF Audit Team determines that a RR is required in disagreement with a NF's finding, the Medicaid NF Audit Team will:

a) certify its decision, explaining the reason RR is needed on the Audit Worksheet.; and
b) promptly contact the CMHC or D&E Team to do a Level II

The need for RR Level II assessment should be certified by:

a) the CMHC or BDDS Office on page 4 of the Level II: Mental Health Assessment for future Yearly RR assessments; or
b) the NF for significant-change in condition in its referral letter to the CMHC or BDDS Office.

14.1.3 CMHC and D&E Team Action

Upon receipt of a NF referral, the CMHC or D&E Team must:

a) review all submitted materials; and
b) identify what kind of RR is being referred; and
c) make a decision regarding the individual's need for and appropriateness of a Level II assessment.

The CMHC or D&E Team should resolve any questions, inconsistencies, or lack of information in the NF referral by contacting the initiating NF.

The finding may be that:

a) RR Level II is required (YRR, Significant-Change, or "Missed Level II");

b) RR is not required at this time; or
c) RR should be deferred due to a resident's inability to participate in the assessment.

When it is decided that RR is not required or should be deferred:
a) the CMHC will document its decision on an MI: Inappropriate Referral form; or
b) the D&E Team will document it in writing on company letterhead.
The completed MI: Inappropriate Referral form or D&E Team letter will explain the circumstances related to the deferral decision.

Decisions to defer a RR Level II should first consider:
a) the reported seriousness of the individual's mental health or MR/DD condition;
b) need for intervention
c) intensity of anticipated treatment; and
d) provision and efficacy of interim mental health and/or MR/DD services.

When the Level II is deferred, the NF is responsible to monitor the individual's condition and make referral to the CMHC or D&E Team when the individual becomes able to participate in Level II. The D&E Team will inform the BDDS Office.

The CMHC or D&E Team will take action to conduct the necessary Level II assessment and forward it to the State.

PASRR Unit or BDDS Office for final determination within the following time frames.

14.1.4 NF Transfers and Readmissions

Residents who are transferred between NFs, with or without a hospital stay, are subject to RR. Prior to admission, the NF will need to assure that required PAS or RR Level II assessment was completed. As soon as it is determined that:
a) the PAS was missed in that an individual has been a NF resident for more than one (1) year; and/or
b) the PAS 4B has already been issued;
c) the “Missed PAS” requires a RR Level II.

14.1.4.1 Transfers

An "interfacility transfer" occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay.

PRIOR to transfer, the admitting NF should:
a) ensure that timely PAS and/or PASRR assessment was completed, if required, in the discharging NF;
b) obtain a copy of applicable and available documentation, including but not limited to:
   1) the last Level I form and Application;
   2) most recent Level II;
   3) current medical information, certified Form 450B (Physician’s Certification), nurse's notes and the most recent MDS; and
c) preview all documents, including the Level II, for use in care planning for the transferring resident and to assure that it accepts only those individuals whose needs the NF can meet; and
d) review all records to ascertain whether the Level II is current, i.e., whether a significant change occurred in mental health or MR/DD condition and the required Level II for this change in condition was completed.

The discharging NF must:
a) send to the new (admitting) NF originals or copies of the resident's documentation, as applicable and available:
   1) most recent Level I and Application;
   2) most recent certified Form 450B, Physician’s Certification;
   3) most recent PAS or RR Level II and MDS reports;
   4) PAS Form 4B; and
   5) current medical information, including nurses’ notes; and
b) if there has been a change in condition which requires a RR, complete a new

Significant-Change RR PRIOR to the transfer.

Following admission, the new NF will ascertain:
a) if Yearly RR is required:
1) as noted in the service recommendations portion (page 4) of the MI Level II or on the MR/DD Certification; and
2) if needed, notify the local CMHC or D&E Team/BDDS Office of each transfer from another NF who requires Yearly RR; and/or
b) if Significant-Change RR was needed:
1) but not completed; and
2) notify the local CMHC or D&E Team and submit the necessary documents for Level II to be completed.

Need for Yearly RR should be noted on the resident's chart and flagged for quick reference for requests from the Medicaid NF Audit Review Team.

14.1.4.2 Readmissions from Hospital

An individual is a "readmission" if he or she:
a) has been receiving continuous medical care in a NF prior to hospitalization; and
b) is readmitted to a NF (the same or a different NF) from a hospital to which he or she was transferred for the purpose of receiving care.

There is no limit to the type or length of hospital stay. (For purposes of IPAS and PASRR, the Medicaid 15-day bed-hold is not applicable.)

Under PASRR, an individual's readmission to the same or a different NF depends on:
a) the type of care provided in the acute care hospital bed; and
b) if PASRR Level II is needed, whether a current Level II exists for the individual.

NOTE: A PASRR Level II is considered "current" until the individual has a significant change in mental health or MR/DD condition, as applicable.

14.1.4.2.1 Prior PAS or RR Level II

Prior to discharge to the NF, the hospital discharge planner will need to:
a) identify if the individual has been hospitalized for inpatient psychiatric care (in a designated psychiatric unit or other inpatient bed); and
b) coordinate with the NF from which the individual was admitted to determine if the individual has a current Level II.

When there is a current Level II, the NF may directly readmit the individual and have the new Significant-Change RR Level II completed after readmission.

Prior to but no later than at the time of readmission, the hospital must provide a letter of assurance with the following documentation to the NF:
a) the patient is stable and not a danger to him/herself or others; and
b) information on the mental health services the individual needs after NF readmission.

This information must be retained in the resident's active record at the NF in lieu of a new Significant-Change RR, replaced by the RR Level II done following the readmission.

After the individual has been readmitted, the NF will promptly:
a) notify the CMHC or D&E Team/BDDS Office of need for a Significant-Change RR; and
b) send a copy of the hospital's letter of assurance with other referral documentation to the CMHC or D&E Team.

NOTE: If Yearly RR falls due during a hospital stay for medical only care, the NF will notify the CMHC or D&E Team as soon as the resident is readmitted. The Level II will be performed within the required quarter or no later than the quarter immediately following readmission to a NF.

14.1.4.2.2 No Prior PAS or RR Level II

The NF must not readmit the individual until a PASRR determination has been rendered.

When the hospital determines that the individual:
a) does NOT have a current Level II;
b) but has had a significant change in mental health or MR/DD condition; and
c) requires a Significant-Change RR Level II:
the Significant-Change RR must be completed PRIOR to readmission to a NF.

NOTE: For MI, the Level II may be completed by either the CMHC or the hospital in which the resident is an inpatient. For MR/DD, it must be completed by the D&E Team.

When a hospital completes the PASRR/MI Level II: Mental Health Assessment for an inpatient, PRIOR to readmission of the resident it will:
a) obtain a new Form 450B, Physician Certification; and
b) prepare a FAX packet with a FAX cover sheet clearly noting that the Level II is for Significant-Change: and
c) FAX the cover letter, Level II, new Form 450B, discharge summary and other pertinent documentation to the State PASRR Unit for determination.
The MI Level II will be processed as follows:
a) the State PASRR Unit will promptly issue a PASRR determination letter/certificate to the identified hospital; and
b) the hospital must provide to the selected NF (no later than at admission):
   1) the case documents which were FAXed to the State PASRR Unit, including the original MI Level II; and
   2) the FAX copy of the PASRR determination letter/certificate.

14.1.5 RR Level II Assessment

See Chapter 13 for information about the PASRR Level II assessment form and process.

In addition, the RR Level II assessor should always:
- include a face-to-face interview with the resident; and
- review the resident's MDS, pertinent chart documentation, and available materials from other sources which pertain to the Level II assessment.

When a hospital completes the PASRR/MI Level II assessment for a patient in an acute care bed, it should also coordinate the assessment with information from the NF and the most recent MDS, whenever possible.

The RR is an interactive process with the NF's assessment and care planning system in which the MDS and Level II assessment complement each other. The hospital, CMHC and D&E Teams will:
a) utilize documentation and information found in the current MDS;
b) confer with the NF staff as necessary concerning areas of discrepancy or inaccuracy; and
c) respond to and resolve questions from the resident, responsible person, and NF.

NOTE: The CMHC or D&E Team will conduct the mental health or DD portion of the Level II assessment to the point that necessary findings can be made. When applicable, the CMHC will use the Inappropriate Referral form to document why a complete MI Level II assessment was not done. The D&E Team will document its findings on its letterhead.

The D&E Team must notify the BDDS Office when the referral is received.

The NF must:
a) utilize the findings of the RR in its care planning and service provision for each resident; and
b) share questions which arise concerning a resident's MI and/or MR/DD condition and functioning in consultation with the Level II assessor(s).

14.2 "SIGNIFICANT-CHANGE IN CONDITION" RR

Federal regulations require a NF to monitor each resident's condition and, when there is a significant change in MI or MR/DD condition, make a referral to the CMHC or D&E Team for a new Level II assessment. The following procedures apply to "Significant-Change" RR assessments.

14.2.1 Identification of Significant-Change

For residents with MI and/or MR/DD conditions, the NF must:

a) monitor each resident's condition; and

b) determine whether, based on "significant change in condition" criteria defined in the MDS, there has been a significant change in the resident's condition which would have a bearing on his or her mental health or overall MR/DD functioning needs; and

c) make necessary referrals for Significant-Change RR.

NOTE: When a Level II assessment was required but not completed, it is the responsibility of the NF to make referral for "Missed RR."

14.2.2 Referral for Significant-Change RR

The NF must:

a) make referral for Significant-Change RR Level II to:

1) the local CMHC for residents with MI conditions; or

2) the D&E Team for residents with MR/DD;

b) within the time frames of Chapter12.2.3.

RESIDENT REVIEW (RR) PASRR *(Chapter 14)*

Referral for PASRR RR Level II

Tracking by CMHC or D&E Team	By NF	By Medicaid Audit Review Team
CMHC and D&E Team maintain a log of residents needing YRR: 1. From Prior Level IIs; or 2. NF notification of new admissions with Level IIs	Referral from NF to CMHC or D&E Team must include: 1. Letter of explanation 2. Medical information 3. Hospital letter of assurance (When applicable) 4. PAS Form 4B OR Certified/Authorized 450B (Secs§ I-III)	Referral from Medicaid Audit Team to CMHC or D&E Team must include: 1. Explanation of referral 2. Other backup documentation

Types of RR Level II Assessment

Yearly RR (YRR)	Significant-Change RR (SC-RR)	"Missed" Level II
Identified via PRIOR Level II with finding of: 1. Is MI; and 2. Needs MH Services; and 3. Needs YRR; and 4. NOT currently client of CMHC. OR Identified via PRIOR MR/DD or MR/DD/MI Level II finding:	Identified via NF using criteria from Minimum Data Set (MDS) of Resident Assessment (RA) When change in condition, NF: 1. Begins treatment and begins comprehensive MDS reassessment; 2. Within 14 days, completes MDS reassessment; 3. Within 7 additional	Identified as "Missed Level II" because Level II was required but was not completed: 1. Should have been completed as part of PAS, but not done prior to PAS final determination; 2. Required YRR Level II, but was not completed; 3. Significant-Change in condition occurred more than 30 days prior to date of Level II referral.

Missed PAS **Missed YRR** **Missed SC-RR**

1. Is MR/DD or MR/DD/MI; and
2. Needs specialized services; or
3. Needs specialized rehabilitation services related to a DD; and/or
4. Needs YRR.

Level II Time Frame: Occurs within 4th quarter after previous PAS or RR Level II (Mailed)

days, revises care plan;

4. No later than 21st day following change in condition, identifies whether meets significant-change criteria and needs RR;

5. If RR, promptly refers to CMHC or D&E Team.

Level II Time Frame: Within 7 to 9 working days of the NF referral. (Within 30 days following significant change in resident's condition) (Faxed)

Level II Time Frame: Within 30 days following date of NF or Medicaid Audit Team referral (Mailed/Only Fax if time is critical)

Case Packet Contents for PASRR RR Level II

YRR; "Missed" PAS; "Missed" YRR

1. CMHC Referral Checklist (for MI Cases) or Referral Letter (for DD Cases)
2. Level II Assessment
3. PAS Form 4B or Certified /Authorized Form 450B (Secs I-III - Physician Certification of Long-Term Care Services)**
4. Other (Optional)

Significant Change RR (SC-RR); "Missed" SC-RR

1. CMHC Referral Checklist (for MI Cases) or Referral Letter (for DD Cases)
2. NF Referral Letter
3. Hospital Letter of Assurance (When Applicable)
4. Level II Assessment
5. Medical Documentation of NF Level of Services Need*
6. PAS Form 4B or Certified /Authorized Form 450B (Secs I-III - Physician Certification of Long-Term Care Services)**
7. Other (Optional)

Forward MI Cases to State PASRR Unit -- OR -- Forward MR/DD & MI/MR/DD Cases to BDDS Field Office

Final Determination

* NF must provide documentation to show NF Level of Services need. Documentation may be on a new (non-certified/non-authorized) Form 450B, Secs I-III; OR a prior certified Form 450B with additional information attached; OR nurses notes; etc.

The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF. When insufficient, the State PASRR Unit will get additional information directly from the NF.

** A case may contain two (2) Forms 450B (Secs I-III): ¬ a non-certified/non-authorized form to establish NF Level of-Services need; and a certified/authorized form to establish IPAS compliance.

a) no later than the 21st day following the change in condition, the NF must identify whether the change meets the criteria for a "significant change in condition" and requires a RR; and
b) if a RR is needed, the NF must promptly make a referral to the appropriate CMHC or D&E Team.

The D&E Team must inform the BDDS Office.

"Promptly" means that the action must begin immediately.

NOTE: When inpatient psychiatric care is needed, the NF should not wait for these time limits to obtain care or services for the resident. Inpatient psychiatric care should be provided as soon as it is identified that it is needed.

The significant change in condition may or may not require hospitalization. (If the resident is hospitalized, but does not have a current PAS or RR Level II assessment, the RR must be completed and a determination made prior to readmission. See Chapter 12.1.4.)

NOTE: The NF should never delay provision of necessary services, including inpatient psychiatric care, pending PAS or RR Level II assessment. When there is a significant change in condition, the NF should promptly contact the CMHC or D&E Team or another appropriate service provider for the resident.

"Promptly" means that the action must begin immediately within the guidelines of Chapter 12.3.5.

14.2.3 MDS Time Limits for NF

MDS criteria sets specific time limits for the NF to identify whether there has been a "significant change in physical or mental condition." The NF may make referral for Significant-Change RR sooner than this time frame; but it should not be later.

Following the time frames given below, the NF should make Significant-Change RR referral no later than 21 days following the change:

c) when there is a change in condition, the NF must begin treatment to meet the resident's immediate needs and begin a comprehensive MDS reassessment;
d) within 14 days of the change, the NF must complete the MDS reassessment;
e) within 7 additional days, the NF must revise the resident's care plan based on the comprehensive reassessment;

14.2.4 Referral Process for Significant-Change RR

The NF will:

a) promptly initiate the RR referral directly to the CMHC or D&E Team, as appropriate;
b) in writing, including the following:
   1) a letter from the NF explaining the change in condition which requires significant-change RR (when more than one resident is referred at a time, prepare a separate letter and packet for each resident);
   2) documentation to establish medical level of services need, which may include but is not limited to:
      i) a copy of the most recent MDS; and/or
      ii) a new Form 450B, Physician's Certification for Long-Term Care Services; and/or
      iii) a prior certified Form 450B, Physician’s Certification, plus additional information; and/or
      iv) applicable nurses’ notes; and/or
      v) other appropriate documentation as determined by the NF; and
      for residents readmitted following discharge from hospitalization for a change in mental health or MR/DD condition, a copy of the hospital's letter of assurance to the NF.

      NOTE: The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF. When insufficient, the State PASRR Unit will get additional information directly from the NF.

      NOTE: A NF Audit Team Worksheet, Form 450B, MDS, or other documentation are

considered to be "current" when they reflect the resident's condition at the time of the Level II.

For accountability purposes, it is recommended that the NF should:
a) retain a copy of the referral letter to the CMHC or D&E Team; and
b) follow-up with a telephone call to assure that the referral was received and directed to the appropriate individual within the CMHC or D&E Team.

This process applies to all residents who have experienced a significant change in condition, whether hospitalized or remaining in the NF.

14.2.5 Time Limits for Significant-Change RR

The full RR assessment and determination must be completed within applicable time frames, calculated as follows:
a) the NF must notify the CMHC or D&E Team of the need for a significant change resident review within 21 days of the significant change in condition (See Chapter 12.2.); and
b) the full RR Level II assessment from the date of referral from the NF to the final determination from the State PASRR Unit must be completed within an annual average of 7 to 9 working days of the NF referral.

Thus, the RR will be completed within 30 days following the actual significant change in the resident's condition.

14.2.5.1 CMHC and State PASRR Unit Time Limits

The CMHC will:
a) complete the Level II assessment as soon as possible; and
b) submit the Significant-Change RR packet to the State PASRR Unit as soon as possible;
c) but no later than four (4) working days from the date of referral by the NF.

To expedite processing to meet time limits:
a) the CMHC may FAX a copy of the case packet to the State PASRR Unit; and
b) the State PASRR Unit will issue the PASRR RR Determination Letter by return FAX to the CMHC.

The CMHC will:
a) make a copy of the determination Letter for its file; and
b) attach the original to the case packet, and forward the entire case to the appropriate NF for the resident's chart.

The State PASRR Unit will review the packet and issue the Level II determination as soon as possible, but no later than one (1) working day from the date of receipt.

14.2.5.2 D&E Team and BDDS Office Time Limits

The D&E Team will:
a) complete the Level II assessment as soon as possible; and
b) submit the Significant-Change RR packet to the BDDS Office as soon as possible;
c) but no later than four (4) working days from the date of referral by the NF.

The BDDS Office will review the packet and issue the Level II determination as soon as possible, but no later than one (1) working day from the date of receipt.

The BDDS Office will coordinate its action with the State PASRR Unit as required.

14.3 "MISSED LEVEL II" RR

Regulations specify that a Medicaid-certified NF must not admit or retain an individual who requires Level II, but has not been assessed and a determination made. Therefore, at any time that a missed Level II is identified, the Level II must be completed or the individual can no longer remain in a Medicaid-Certified NF.

A "Missed Level II" denotes a situation in which a Level II was required but was not completed in a timely manner. A "Missed Level II" may be for:
a) "PAS:"

1) required Level II was not completed; or
2) deferred Level II should have been triggered as a RR within a specified time following admission to a NF, but was not; or

a) "Yearly RR:" a YRR was not done; or
b) "Significant-Change RR:" a change in condition occurred more than thirty (30) days prior to the date referral should have been made by the NF.

"Missed Level II" may be identified and referred for assessment by:
a) the NF;
b) the Medicaid NF Audit Team;
c) the State OMPP or State PASRR Unit; or
d) the CMHC or D&E Team/BDDS Office.

"Missed Level II" assessments will:
a) follow the procedures for Significant-Change RR; except that
b) the Level II must be completed no later than 30 calendar days following the date of NF or Medicaid NF Audit Team referral.

14.4 "YEARLY" RR

Need for Yearly RR (YRR) assessments will be identified as a result of a prior PAS or Significant-Change RR or current YRR Level II. The CMHC or D&E Team will schedule YRR assessments throughout the year.

For each resident who had a PASRR Level II assessment, a NF should always:
a) determine whether the resident will require a Yearly RR as indicated on:
1) for MI, page 4 of the Level II: PASRR/MI Mental Health Assessment (see Appendix Z) will be checked whether YRR is needed; and
2) for MR/DD, the Pre-Admission Screening/Resident Review Certification for Nursing Facility Services form (see Appendix CC); and
b) promptly notify the local CMHC or D&E Team/BDDS Field Office of new admissions which transfer from another NF who need Yearly RR.

14.4.1 YRR: Purpose

In addition to the purposes of the Level II assessment discussed in Chapter 13, the purpose of the YRR is to ascertain and document:
a) whether the resident is receiving identified and needed mental health and/or MR/DD services;
b) why a resident, identified as needing mental health and/or MR/DD services but not receiving them, is not provided these services;
c) changes in required mental health and/or MR/DD services; and
d) whether the resident will continue to require Yearly Resident Review.

14.4.2 YRR for MI Residents

a) Residents who require YRR are those who have previously been assessed under PAS and/or RR Level II and found:
b) to be MI; and
a) to need mental health services; and
b) to NOT currently be under treatment or monitoring by an Indiana CMHC and have not been previously reviewed to assure that:
1) an appropriate plan of care has been developed and followed; and
2) necessary mental health services are provided; and
d) by the State or State contractors (i.e., CMHCs) to require Yearly Resident Review.

NOTE: For YRR NF residents who are current CMHC clients, the CMHCs should:
a) continue tracking;
b) but not complete YRR unless the CMHC is notified that the resident has had a significant change in condition.

14.4.3 YRR for MR/DD and MR/DD/MI Residents

Residents who require YRR are those who have previously been assessed under PAS and/or RR Level II and determined:

a) to be MR/DD or MR/DD/MI and require specialized services; or
b) to be MR/DD or MR/DD/MI and require specialized rehabilitation services related to a developmental disability; or
c) by the State or State contractors (i.e., D&E Teams) to require Yearly Resident Review.

14.4.4 Recording YRR Decision

At each PAS and RR Level II assessment, the CMHC or D&E Team/BDDS Office will identify residents needing YRR follow-along as part of the service(s) findings.

This determination will be recorded in the services identification section of the Level II assessment. The appropriate box should be checked or a short notation entered stating, "Yearly RR Required."

14.4.5 Tracking YRR

TRACKING: It is the responsibility of each CMHC and D&E Team/BDDS Office to maintain a log and tracking system for:
a) those NF residents in its geographic area who require Yearly RR review; and
b) (for CMHCs) those NF residents in other geographic areas for whom the CMHC is the gatekeeper.

NOTIFICATIONS: In order to track residents needing YRR, the following notifications will need to occur:
a) each IPAS agency will:
   1) send to the CMHC (for MI) or D&E Team (for MR/DD/MI) a copy of the form PAS 4B of PAS Level II assessments; and
   2) if the NF designation on the PAS 4B is "Undecided," notify the CMHC or D&E Team of the NF's name and address when the IPAS agency determines the specific NF to which the IPAS case packet should be sent; and
b) each NF must:
   1) identify admissions and transferred residents who need YRR; and
   2) notify the local CMHC or D&E Team of transfers from other NFs (directly or via the hospital) who need YRR.

The D&E Team will notify the BDDS Office of the transfer.

The names of individuals determined to need YRR shall be added to the tracking log of the CMHC or D&E Team/BDDS Office. (And the CMHC or D&E Team/BDDS Office will delete from its log the name of a resident who has left its catchment area, unless the CMHC is the gatekeeper.)

For MI, the CMHC will:
a) maintain a log and tracking system for Yearly RR;
b) conduct Level II assessments, determine the mental illness diagnosis and the need for mental health services and Yearly RR;
c) compile a Level II case packet for submission to the State PASRR Unit; and
d) confer and coordinate with the NF on the needs of residents who require RR.

For PASRR/MR/DD or MR/DD/MI, the D&E Team will:
e) maintain a tracking system and log of individuals who require yearly resident review;
f) notify the local BDDS Field Office that:
   1) a RR due to a significant change has been requested; or
   2) a yearly resident review is due;
g) conduct the MR/DD Level II assessment; and
h) submit the case packet to the local BDDS Field Services Office.

NOTE: For NF transfers:
a) the first NF must promptly provide a copy of the last Level II assessment, certified Form 450B (Physician Certification), form PAS 4B, and Level II determination to the second NF; and
b) the receiving NF should provide a copy of the Level II to the local CMHC or D&E Team when the Level II was completed:
   1) by a hospital; or

2) by a CMHC or D&E Team from another area.

14.4.6 Timeliness for YRR

As a general guideline, "Yearly" is defined as occurring within every fourth quarter after the previous PAS or RR Level II. "Calendar quarter" is defined as one of the time periods consisting of:

1st Quarter: January 1 through March 31
2nd Quarter: April 1 through June 30
3rd Quarter: July 1 through September 30
4th Quarter: October 1 through December 31

Since YRRs are a state and not a federal requirement, CMHCs and D&E Team should set up a general schedule for each NF in its area for YRR, spreading the NF YRR reviews throughout the year. Once this is established, the above guideline should be adhered to as much as possible.

NOTE: A YRR may be earlier, but should not be later, than the end of the quarter in which the anniversary date of the previous PAS or RR Level II falls. (For example, if the last Level II assessment applicable signature date is April 15, 1993, then the next Level II assessment is due no later than June 30, 1994.)

As YRR will no longer be linked to an annual NF visit by the Medicaid Audit Review Team, yearly assessments will occur when necessary throughout the year. However, to reduce costs, every attempt should be made to batch together Level IIs by NF. Logs maintained by the CMHC and D&E Teams will track due dates.

NOTE: Significant-Change RRs mandated by federal regulations should always receive first priority. YRRs may be slightly delayed for completion of Significant-Change RRs. When delay for YRR occurs, the CMHC or D&E Team should briefly explain circumstances on the Level II.

14.4.6.1 Level II Effective Date

The effective date of the YRR Level II is:
a) the psychiatrist's signature date on the most recent MI Level II assessment; or
b) the most recent signature date on the DD Level II assessment.
This date becomes the applicable anniversary date to determine the quarter in which the next Yearly RR is due.

14.4.6.2 "Missed YRR" Level II

A required YRR may be "missed" and should be completed as soon as possible, but no later than 30 days following referral or discovery that it was missed. (See Chapter 12.4)

14.5 ACTION WHEN SERVICES NOT PROVIDED

At each Level II assessment, the CMHC and D&E Team assessor will:
a) review the resident's chart, prior Level II, and other documentation during the completion of the YRR; and
b) determine whether identified mental health and/or MR/DD services were provided for the resident.

The Medicaid NF Audit Team will also:
a) review the resident's records and most recent Level II during its audit activities; and
b) determine whether the NF includes identified mental health and/or MR/DD service needs in the plan of care and providing, or making provision for, identified mental health and/or MR/DD services.

When the finding is that services were not provided and there is not an acceptable reason to explain why not, the following action will be taken, as appropriate:

a) MI mental health services:
   1) the CMHC or Medicaid NF Audit Team will confer with the NF to ascertain why services were not provided; and
   2) the CMHC or Medicaid NF Audit Team will document its findings; and
   3) make a referral to the Long-Term Care Services Division of the Indiana Department of Health for follow-up;
b) MR/DD and MR/DD/MI services:
   1) the D&E Team or the Medicaid NF Audit Team will document its findings; and
   2) notify the BDDS Office and the Indiana Department of Health, Long-Term Care Services Division for follow-up.

14.6 MEDICAID NF AUDIT TEAM FINDINGS AND PASRR RR

Under RR procedures, a PASRR Level II Mental Health Assessment or MR/DD assessment is considered "current" until there is a significant change in a resident's mental or MR/DD condition, regardless of the length of time since it was completed.

A determination of need for NF level of services by the Medicaid NF Audit Team includes the "current" PASRR Level II Mental Health Assessment or MR/DD/MI assessment. A new PASRR Level II: Mental Health Assessment or MR/DD/MI assessment are only needed if the resident's mental or DD condition significantly changed and a new assessment was not requested or a required Yearly RR was not completed.

A discharge finding may be based on one of the following:

a) no need for NF level of services and no need for specialized services, regardless of length of stay;
b) no need for NF level of services and need for specialized services, for a NF resident of less than 30-months; or
c) need for specialized services, regardless of need for NF level of services, for a NF resident of less than 30-months.

As part of its decision-making protocol, the Medicaid NF Audit Team should:

a) get a copy of the "current" Level II: Mental Health Assessment or MR/DD assessment from the NF;
b) determine whether there has been a "significant change" in the resident's mental or DD condition since the last Level II was completed; and
c) ascertain whether the "30-month" rule applies. (See Chapter 17 of the Manual.)

NOTE: The Medicaid NF Audit Team should refer for a new PASRR Level II: Mental Health Assessment by the CMHC or Level II DD assessment by the D&E Team only when there has been a significant change. The nature of the significant change should be clearly documented. The decision for discharge may only be due to lack of need for NF level of services.

CHAPTER 15
PASRR AND THE MEDICAID WAIVER

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 15
MEDICAID WAIVERS AND PASRR

15.1 PASRR RELATIONSHIP TO MEDICAID WAIVERS

The following supplements procedures given in Chapter 7 of this Manual. Medicaid Waiver Services are those specific in-home and community-based services available for Medicaid reimbursement only under a federally approved "waiver" of certain federal regulations.

PASRR applies to:
a) Indiana's "Aged and Disabled (A&D) Waiver;"
b) Indiana's "Medically Fragile Children's (MFC) Waiver;" and
c) Indiana's "Traumatic Brain Injury (TBI) Waiver;"
two (2) of Indiana's Medicaid Waivers which provide services to aged adults and persons with disabilities who would otherwise require the level of services provided in a NF.

In addition, the ICF/MR and Autism Waivers require a complete PASRR PRIOR to NF admission and do not qualify for the "freedom of choice" provision to enter a NF.

Recipients of these Waivers must be given the "choice" between receipt of Medicaid Waiver services or admission to a NF. Therefore, he or she must meet all requirements for NF placement.

NOTE: As always, the NF must not admit any applicant without IPAS and/or PASRR approval for NF temporary or long-term admission.

15.2 GENERAL ELIGIBILITY REQUIREMENTS

For general instructions, also review Chapter 7 of this Manual. Medicaid Waiver eligibility requires that the individual must be:
a) eligible for Medicaid; and
b) at risk of institutionalization (in the absence of Medicaid Waiver services).

The criterion of "at risk of institutionalization" means that the individual must, but for utilization of the Medicaid Waiver service(s), meet all requirements for NF admission and residency. An individual who qualifies for the Medicaid Waiver must be given a choice to accept the Medicaid Waiver service(s) or be admitted to a NF.

15.3 PASRR REQUIRED

IPAS program requirements must be met when an individual applies for Medicaid Waiver services. PASRR requirements, however, do not apply until the time that the recipient chooses placement in a NF.

PASRR criteria, applied at the time that NF placement is chosen, includes:
a) the entire Level II assessment and determination, if needed, completed PRIOR to NF admission; or
b) temporary admission under PASRR Exempted Hospital Discharge, PASRR Respite or PASRR APS categorical determination, if all requirements are met.

Both the selected NF and the Waiver case manager have responsibilities for NF admission of Medicaid Waiver recipients.

15.3.1 NF Action

Often the NF will be the first entity to identify that an applicant is on a Medicaid Waiver. The NF should:
a) ask the applicant or legal representative when completing or reviewing the IPAS Application whether the applicant receives Medicaid Waiver services; and
b) review Level I and other information for need for PASRR Level II.

- When a Medicaid Waiver recipient does not need PASRR Level II, the NF:
  a) may admit the individual after receiving a copy approving NF placement on either:
     1) PAS Form 4B (Appendix P); or

2) Medicaid Waiver form, HCBS Form 3: Statement for Freedom of Choice (Appendix S); and

b) must notify the IPAS agency of the admission.

NOTE: When the above criteria are met, IPAS should not be completed again. The NF will seek Medicaid reimbursement following directions in Chapter 15.4.

- When a Medicaid Waiver recipient does require PASRR Level II, the NF will:
  a) not admit the individual; and
  b) obtain a determination form approving NF placement which is either:
     1) PAS Form 4B (Appendix PAS); or
     2) Medicaid Waiver Form, HCBS Form 3: Statement for Freedom of choice (Appendix S); and
  a) immediately notify the IPAS agency to trigger the PASRR Level II assessment.

NOTE: Only the IPAS agency can authorize the CMHC or D&E Team to complete a Level II for the Medicaid Waiver recipient. The Level II will be done for PAS.

15.3.2 IPAS Agency Action

The IPAS agency may find out that a Medicaid Waiver recipient is choosing NF placement from a number of sources: the case manager, the NF, the recipient.

When PASRR Level II is needed, the IPAS agency will:
a) review and certify need for Level II;
b) immediately notify the CMHC or D&E Team to complete a PAS Level II;
c) prepare a case packet containing the following documentation:
   1) Application for Long-Term Care Services;
   2) PASRR Level I;
   3) HCBS Form 3 or HCBS Form 7;
   4) PASRR Level II;
   5) additional documentation as submitted or necessary;
   6) PAS Form 4A;
c) assure notification of intent to enter a NF is given to the Medicaid Waiver case manager;
d) submit the case packet to the State PASRR Unit for review and determination; and
e) finalize the case according to IPAS and PASRR procedures.

Before submitting the case packet, the IPAS agency should make a clear, visible notation on the first page that it is a “Medicaid Waiver case.”

When the NF takes a new Application for Long-Term Care Services in error, the IPAS agency will:
a) mark the Application as “Void;”
b) return it to the originating NF; and
c) assure that the NF has a copy of the HCBS form and understands the process for Medicaid Waiver.

15.3.3 Medicaid Waiver Case Manager Action

Although the NF is responsible to assure that Level II is completed within program requirements, the Medicaid Waiver case manager will need to take action to discontinue the Medicaid Waiver services.

The Waiver case manager will:
a) verify that the recipient is planning to enter the NF;
b) ascertain proposed length of stay; and
c) follow Medicaid Waiver procedures to discontinue services and do necessary follow-up.

15.4 NF REQUEST FOR MEDICAID REIMBURSEMENT

Following usual procedures, a NF can request Medicaid per diem reimbursement. When PASRR is required, the NF will receive a PASRR Certification form with the PASRR portion of the IPAS/PASRR determination. Then NF will:
a) request Medicaid reimbursement in the usual manner;

b) attach a copy of the:
   1) HCBS 3 (instead for the Form PAS 4B); and
   2) PASRR Certification form; and
c) clearly mark the submission to OMPP as, “Medicaid Waiver Services recipient transferring to the NF” or a similar notation.

NOTE: See flow chart for PASRR and Medicaid Waiver on next page.

PASRR AND THE MEDICAID WAIVER PROCESS
Chapter 15

Medicaid recipient applies for NF admission:

NF asks applicant whether he or she receives Medicaid Waiver

YES

1. New Application not needed;
2. Form 450B not needed; but
3. needs new Level I; and
4. NF sends Level I to IPAS Agency with explanatory note

NO

NF must:
1. take Application;
2. get current Form 450B; and
3. get Level I; and
4. send all to IPAS Agency

IPAS Agency:
1. researches/confirms whether Waiver recipient;
2. reviews all documents; and
3. certifies Level I.

Yes, is Waiver recipient. IPAS has already been completed as part of Waiver eligibility; do not complete again. Determine need for PASRR Level II.

No, is not Waiver recipient.

Follow established IPAS and/or PASRR procedures.

PASRR Level II Not Needed

IPAS agency:
1. gets copy of HCBS 3;
2. sends HCBS 3 and certified Level I to NF;
3. notifies Waiver case manager;
4. updates IPAS agency records;
5. advises NF to send documentation to OMPP for reimbursement (Chapter 15.4)

PASRR Level II Needed

IPAS agency:
1. gets copy of Form HCBS 3;
2. notifies Waiver case manager;
3. sends NF copy of certified Level I and HCBS 3
4. makes referral for Level II to CMHC or D&E Team;
5. prepares case packet (Chapter 13.3.2)
6. sends it to the State PASRR Unit

State PASRR Unit:
1. reviews case record and makes determination;
2. issues “PASRR Certification” form to IPAS agency:
   a. sends with case packet to NF;
   b. sends copy to CMHC or BDDS Office, as appropriate.

CHAPTER 16
RR/PASRR “CHOICE” FOR SPECIALIZED SERVICES

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTER 16
RR/PASRR “CHOICE” FOR SPECIALIZED SERVICES

16.1 "CHOICE" OF SPECIALIZED SERVICES’ SETTING

Federal regulations provide that certain residents may, under specific circumstances, remain in a NF to receive “RR/PASRR specialized services when they would not ordinarily qualify for continued placement.

(See Chapter 13.5 for PASRR "specialized services.")

When a resident qualifies, information on the "RR/PASRR Choice" options and the treatment decision must be provided to the resident and/or his or her legal representative.

16.2 “RR/PASRR CHOICE”

For PASRR purposes, a “long-term resident” is a NF resident who has resided continuously in one or more NFs including brief hospitalization.

The “RR/PASRR Choice” refers to
a) does NOT require NF level of services;
b) does need specialized services; and
c) has continuously resided in a NF for at least 30 consecutive months before the date of the RR determination;
d) may choose to receive the specialized services:
   1) while continuing to reside in the NF; OR
   2) in an alternative appropriate institutional or noninstitutional setting.

This “30-month” qualifier:
a) only applies to the RR of PASRR; and
b) all requirements stated above must be met.

In this situation, need for RR/PASRR specialized services is the only need which qualifies the individual for continued NF placement Thus, the resident must receive the identified specialized services or he or she cannot continue to reside in a Medicaid-certified NF.

16.1.1 Qualifying Criteria

Persons eligible for the "RR/PASRR Choice" option must meet ALL of the criteria listed below.

a) NF Resident. The individual must be a current resident of a Medicaid-certified NF.
b) Does NOT Need NF Level of Services. The individual must be determined by PASRR RR NOT to need the NF level of services.
c) Not a danger to self or others. The individual's severe behavioral problems which constitute a potential danger to self or others must be controllable with the provision of specialized services.
d) Is MI and/or MR/DD. The resident's condition must meet the PASRR criteria for MI and/or MR/DD.
e) Needs specialized services. The resident's need for treatment of his or her MI and/or MR/DD condition must be of an intensity to qualify as PASRR specialized services.
f) Resident of a NF for 30-Months or More. For PASRR purposes, an individual is a long-term NF resident if he or she has resided continuously in a NF for 30-months or more, regardless of short-term care in an acute-care hospital (not a state psychiatric facility).

16.2.2 Process to "Offer the RR/PASRR Choice"

When all of the conditions listed above are met, the resident may be offered the "choice" of setting in which to receive his or her specialized services.

16.2.1 Presentation of the "RR/PASRR Choice”

For residents with MI, the local (contact the State PASRR Unit at BAIHS) will contact the resident and offer the "choice."

For residents with MR/DD, the BDDS Field Services Office will be responsible to offer the "choice."

16.2.2 Contents of Presentation.

The following information must be presented to the resident and/or his or her legal representative:

a) information on institutional and non-institutional alternatives covered under the State Plan (Medicaid) for the resident;

b) the "choice" of receiving specialized services in an alternative institutional or non-institutional setting or in the NF;

NOTE: Based on the definition of MI specialized services (services equivalent to inpatient psychiatric hospital care), it usually is not possible for a NF to establish and provide MI specialized services within the NF setting for the individual who needs them.

Due to the episodic nature of most MI, short periods of specialized services treatment may be needed rather than long-term placement. When it is anticipated that provision of specialized services will be for a brief period, and result in stabilization of the condition so that readmission to the NF is possible, the "PASRR/MI Choice" option will not be applied.

NECESSARY TREATMENT AND SERVICES SHOULD ALWAYS BE OBTAINED AS QUICKLY AS POSSIBLE AND SHOULD NOT BE DELAYED AWAITING COMPLETION OF THE PAPERWORK INVOLVED WITH THE LEVEL II PROCESS.

c) explanation that refusal to participate in specialized services will result in discharge from the NF; and

d) clarification of the effect on eligibility for services under the State Plan (Medicaid) if the person chooses to leave the NF (including its effect on readmission to the NF). If this option is chosen, the NF is responsible for doing adequate discharge planning.

16.3 General Guidelines and Procedures

Procedures may need to be adjusted to meet the needs of Individual situations. The following guidelines will assist the (contact the State PASRR Unit at BAIHS) or BDDS Field Services representative to offer the "RR/PASRR Choice."

Note: In no event will the NF or other potential service provider perform this function.

16.3.1 Procedures

a) Identification and Referral. For MI individuals, the State PASRR/MI program specialist will review the RR determinations and make a referral of those residents who qualify for this provision to the State (Contact the State PASRR Unit at BAIHS).

For MR/DD individuals, the BDDS Field Services staff will monitor RR determinations and assure that residents who qualify for this provision are appropriately referred.

b) The referral will be documented in writing in the resident's PASRR/RR case record. As much information as possible relative to the PASRR case will be provided to the identified presenter.

c) The PASRR presenter (contact the State PASRR Unit at BAIHS or BDDS representative) will contact the resident and his or her legal representative, as well as the NF, to set up a meeting. All activities are to be documented in writing in the case record. The findings with the case record will follow the determination procedures for an RR. The PASRR presenter should retain a copy of the records on file.

The purpose of the meeting is to present the PASRR/RR finding, to review all alternatives or options, to answer questions and clarify issues, and to elicit and record the resident's choice. The NF may assist with setting up the meeting, but must refrain from exerting any influence with the resident. Questions should always be referred to the PASRR presenter.

In order to maintain objectivity, the NF or other potential service provider should not attend the meeting, but may provide information to the PASRR presenter.

d) The resident's choice and other pertinent information are recorded in the PASRR case record. The original case is sent to the State PASRR Unit, a copy of the decision is provided to the resident and his or her legal representative, and a copy retained by the PASRR presenter.

16.3.2 PASRR/MI Guidelines

The following procedures, initially developed to meet Indiana's Alternative Disposition Plan (ADP), will be followed to assure that specialized services are available for MI residents identified above who agree to receive them.

a) Refer the identified individual to become a client of the local CMHC, if he or she is not already being followed by a CMHC.
b) Move the individual to an inpatient psychiatric unit housed in, or under contract to, the CMHC.
c) Each individual may be provided with an average of twenty (20) days of inpatient psychiatric care.
d) Individuals whose conditions have stabilized during inpatient treatment in the CMHC may be placed in appropriate residential programs, including but not limited to: supervised group living for persons with MI; semi-independent living for persons with MI; alternative family for adults with MI; and alternative family for children with serious emotional disturbance.
e) Individuals whose conditions have not stabilized within 20 days should be referred for placement in state operated psychiatric hospitals.

NOTE: It is noted that the Division of Mental Health does not have the authority to require individuals to accept mental health services unless that person Is involuntarily committed by court action. Otherwise, the individual has the right to refuse treatment.

For the purposes of this legislation, the resident or his or her legal representative acting in his behalf will be offered alternative services. Anyone not committed to the Division of Mental health has the right under state law to refuse services.

However, a Medicaid-certified NF is prohibited from retaining any resident needing specialized services but refusing such services.

THIS PAGE IS INTENTIONALLY BLANK.

CHAPTERS 17, 18 & 19
RESERVED FOR FUTURE USE

THIS PAGE IS INTENTIONALLY BLANK.